Mental health and suicide prevention Monitoring and Reporting Framework

Complete Final Report to the National Mental Health Commission with Appendices

6 June 2018

nous

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Contents

Executive summary

The National Mental Health Commission (the Commission) engaged Nous Group (Nous) to develop a monitoring and reporting framework (Framework) for mental health and suicide prevention from 2018 to 2022 and into the future. The purpose of the Framework is to enable the Commission to undertake national independent monitoring and reporting on mental health and suicide prevention.

The desired outcome of monitoring and reporting is positive change in the mental health and wellbeing of all Australians, enabling people to lead a contributing life and to be part of a thriving community. The Commission will achieve this by providing insight into outcomes for people with lived experience of mental ill health and suicidality, their carers, families, and support people. Monitoring and reporting will also act as a catalyst for change by informing policy and practice to improve mental health outcomes.

Scope of the Commission's approach to monitoring and reporting on mental health and suicide prevention

The Framework provides a comprehensive overview of the Commission's potential approach to monitoring and reporting on mental health and suicide prevention. The Commission's capacity to deliver on the entire scope is dependent upon the level of resourcing available to it and competing demands within its work plan. At a minimum, the Commission will report against the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan). The Commission could also consider monitoring and reporting on areas of focus arising from the Contributing Life Framework, the National Disability Insurance Scheme (NDIS), Primary Health Networks (PHNs) and state and territory mental health and suicide prevention plans.

An implementation roadmap for the Commission's monitoring and reporting over the 2018-2022 period has also been developed to guide the implementation of the proposed Framework. This roadmap outlines the approach that could be taken to implementation, covering:

- monitoring and reporting formats
- the cycle of reporting
- data sources and reporting frequency
- opportunities for analysis
- stakeholder collaboration.

The Commission will consider how to operationalise the Framework and implementation plan developed by Nous.

Figure 1 on page 6 provides an overview of the proposed Framework. The Framework includes several components:

- The **purpose of the Framework** describes what the Commission could achieve through the Framework.
    - The three **domain categories** describe the broad areas that the Commission could monitor and report. These domain categories contain **focus domains** that have been chosen and prioritised based on stakeholder input as well as significant reform activities (namely the Fifth Plan, the NDIS, the implementation of the PHNs, and state and territory mental health and suicide prevention plans). The domain categories are:
        - *Social* – the broader social factors that impact mental health outcomes of people in Australia, including social determinants and social attitudes that impact on mental health and suicide, and the reform activity that is undertaken in response to these.
        - *System* – the performance of system activities that impact the mental health outcomes of people in Australia.
        - *Outcome* – the status of key mental health and wellbeing outcomes of people in Australia at both the individual and population level, including how social context and system activities change over time.
- The **approach to monitoring and reporting** describes how the Commission could develop monitoring and reporting that best catalyses positive change.
- The **desired monitoring and reporting outcome** describes what the Commission may achieve through its monitoring and reporting.

Figure 2 on page 6 describes the proposed implementation roadmap for the Framework from 2018 to 2022. This includes:

- **Flexible reporting principles** that describe how the Commission could present and communicate insights to cater to a diverse range of audiences.
- An **indicative reporting cycle for a calendar year** which provides an example of what the Commission's monitoring and reporting may look like.

The Commission could monitor and report using a variety of quantitative and qualitative data sources. The Commission's monitoring and reporting could present facts, stories and insights in different ways depending on the audience using a mixture of reporting formats, including media releases, visual media, links to external data sources, snapshot reports, interactive data, focus reports, and the Commission's required reports to the Prime Minister and Health Minister.

The Commission's monitoring and reporting could draw together qualitative and quantitative data to support more detailed analysis than available in current monitoring and reporting. The use of both qualitative and quantitative data can result in rich, evidence-based reporting that better reflects the experiences of consumers, carers, families, and support people than quantitative data alone.

The Commission's monitoring and reporting could depend on the data available, and the Commission could monitor and report on the existence of data gaps. The absence of data may lend the use of other data sources or types of data. Meanwhile, there will be a gradual development of specifications for most of the indicators from the Fifth Plan.

Further detail on the above can be found in the body of the report.

Figure 1 Overview of the proposed Mental Health and Suicide Prevention Monitoring and Reporting Framework

Overview of the Mental Health and Suicide Prevention Monitoring and Reporting Framework

Monitoring and Reporting Framework Purpose: To provide national independent monitoring and reporting on mental health and suicide prevention.

The framework will monitor and report on areas of focus from the Fifth Plan, Contributing Life Framework, NDIS, PHNs, and state and territory mental health and suicide prevention plans

Social domains

A society that promotes positive mental health and wellbeing

- **Alcohol and drug misuse**
- **Community connections**
- **Disability**
- **Early childhood development and positive parenting**
- **Education**
- **Employment**
- **Housing and homelessness**
- **Justice system**
- **Physical health**
- **Stigma and social discrimination**
- Economic
- Technology and e-mental health
- Violence, trauma and neglect

System domains

Person-centred care that supports positive mental health and wellbeing and is available to all

- **Accessibility and equity**
- **Consumer and carer participation and leadership**
- **Continuity and integration of care**
- **Safety, quality and responsiveness**
- **Sustainability, capability and funding**
- Efficiency
- Environment and design
- Legislation
- Research
- Workforce

Outcome domains

All Australians lead contributing lives within thriving communities

- **Broader quality of life outcomes**
- **Mental health outcomes**
- **Prevalence of mental ill health, suicide and suicide attempts**
- Mental health literacy
- Positive wellbeing in the community

Focus domains for 2018-2022 are bolded

NMHC approach to monitoring and reporting:

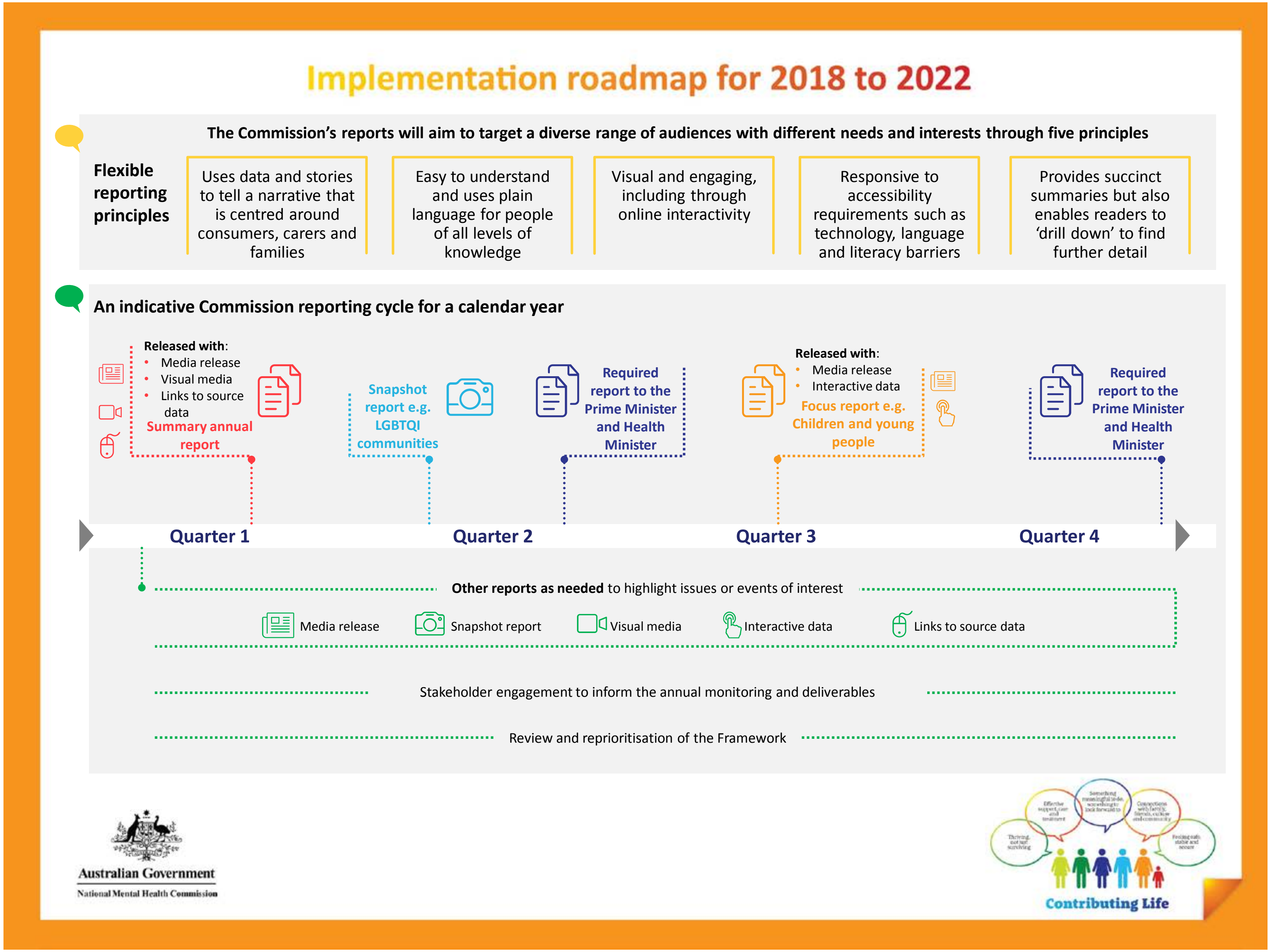
- Consider the reform initiatives through the lens of consumers, carers, families, and support people
- Enable a whole-of-life and person-centred view
- Provide a focus on groups of people in the community with high levels of need and/or limited access to services
- Encompass the continuum of mental health and wellbeing
- Draw attention to interface issues between sectors and services
- Apply an evidence-based approach

Desired NMHC monitoring and reporting outcome: Positive change in mental health and wellbeing for all Australians, enabling people to lead a contributing life and to be part of a thriving community.

Australian Government
National Mental Health Commission

Contributing Life

Figure 2 Proposed implementation of the Mental Health and Suicide Prevention Monitoring and Reporting Framework



Structure of this report

This document details the components of the proposed final Framework and an indicative plan to implement the Framework from 2018 to 2022. The document comprises four sections and five appendices:

- Glossary
- Section 1: Introduction
- Section 2: The Framework
- Section 3: Implementation roadmap for 2018 to 2022
- Section 4: Conclusion
- Appendix A: People and groups consulted with in the development of the Framework
- Appendix B: Stage 2 Consultation Report
- Appendix C: National Consultation Materials
- Appendix D: Environmental Scan Insights Paper
- Appendix E: Organisations and frameworks monitoring and reporting on mental health and suicide prevention.

Glossary

Key terms

Term	Description
Areas of focus	The areas of focus identified in the Framework are key national priorities in mental health and suicide prevention.[1]
Category domain	A specified sphere of activity or knowledge.
Contributing Life Framework	A term first used in the Commission's 2012 National Report Card on Mental Health and Suicide Prevention, which means: A fulfilling life where people with lived experience of mental ill health can expect the same rights, opportunities and health as the wider community. It is a life enriched with close connections to family and friends, supported by good health, wellbeing and health care. It means having a safe stable and secure home and having something to do each day that provides meaning and purpose, whether this is a job, supporting others, or volunteering.
Contributing Lives, Thriving Communities – Report of the National Review of Mental Health Programmes and Services	The Commission's review assessed the efficiency and effectiveness of programs and services in supporting individuals experiencing mental ill health and their families and other support people to lead a contributing life and to engage productively in the community. The Commission provided the Commonwealth Government with the *Contributing Lives, Thriving Communities - Report of the National Review of Mental Health Programmes and Services* in 2014. In late 2015, the Commonwealth Government responded to the Commission's review and presented nine, interconnected areas of reform.
Focus domain	A domain the Commission could focus on over the next five years (2018 to 2022).
Outcomes data	Data that indicates whether, or the degree to which, the intended result or consequence has occurred from a program or activity. An example of an outcome is an increase in a consumer's ability to participate in the community.
Outputs data	Data measuring what has been produced by an activity or group of activities. An example of an output is the number of occasions of service an organisation has delivered.
Population groups	Groups of people that share specific characteristics. For example, a population group can include a certain age, ethnicity or sexual orientation.

[1] At a minimum, the Commission will report against the Fifth Plan. The Commission will also consider monitoring and reporting on areas of focus from the Contributing Life Framework, the NDIS, PHNs and state and territory mental health and suicide prevention plans, to the extent that the Commission is able to within allocated resources.

Acronyms

Term	Description
ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
CALD	Culturally and Linguistically Diverse
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex
MHISSC	Mental Health Information Strategy Standing Committee
MHPC	Mental Health Principal Committee
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NOCC	National Outcomes and Casemix Collection
PHN	Primary Health Network
PREMs	Patient Reported Experience Measures
PROMs	Patient Reported Outcome Measures
YES survey	Your Experience of Service survey

1 Introduction

This section outlines the background, purpose, scope, and development of the proposed Framework.

1.1 Background to the Framework

National monitoring and reporting on mental health and suicide prevention is a core role of the Commission. Since its establishment in 2012, the Commission has conducted this role in various ways, with different formats, structures and areas of focus. Past reports have differed in format and content and have included Report Cards with recommendations in 2012 and 2013, *Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services* (the 2014 Review), a 2016 national report which included personal stories and case studies, and a 2017 national report which reported on the outcomes of the Commission's engagement with stakeholders and work to help shape a mental health system that can respond to peoples' needs more effectively.

Many organisations contribute to the mental health and suicide prevention monitoring and reporting landscape in Australia. However, an environmental scan of recent Australian national mental health and suicide prevention policies confirmed there are gaps and limitations in current monitoring and reporting.[2] There is an opportunity for the Commission to address these gaps and limitations through the proposed Framework, including coverage of policy and reform directions, monitoring and reporting domains, and population groups. There is also potential to improve data sources, analysis, and reporting formats and frequency.

The proposed Framework aims to guide long-term monitoring and reporting of mental health and suicide prevention to provide a comprehensive overview of opportunities for monitoring and reporting on mental health and suicide prevention at a national level while:

- focusing on key reform initiatives at national and state and territory levels
- considering consumer and carer outcomes and experiences
- avoiding duplication of other reporting agencies
- delivering a comprehensive account of reform progress within mental health and related sectors
- being able to respond to changing reform and population priorities.

[2] See the Environmental Scan Insights Paper in Appendix C.

1.2 Purpose and scope of the Framework

The purpose of the proposed Framework is to guide national independent monitoring and reporting of mental health and suicide prevention. The Framework will provide a consistent foundation to structure and guide the Commission's national monitoring and reporting on mental health and suicide prevention over the next five years (2018 to 2022) and into the future.

While the proposed Framework provides a comprehensive overview of the Commission's potential approach to monitoring and reporting on mental health and suicide prevention, the Commission's capacity to deliver on the entire scope is dependent upon the level of resourcing available to it and competing demands within its work plan. At a minimum, the Commission will report against the Fifth Plan. The Commission will also consider monitoring and reporting on areas of focus from the Contributing Life Framework, the NDIS, PHNs and state and territory mental health and suicide prevention plans.

The Commission will consider how to operationalise the Framework and implementation plan developed by Nous.

1.3 Development of the Framework

The Commission engaged Nous to develop the Framework using a three-staged methodology:

- Stage 1 – Initial consultations conducted with key stakeholders (see further details in Appendix A) and developed the Environmental Scan Insights Paper (see Appendix D) that offers insights into the current reporting landscape.
- Stage 2 – Draft Framework materials developed, and national consultations involving workshops conducted in capital cities with a cross section of stakeholders, face-to-face meetings and teleconferences with key stakeholders, and an online public consultation survey. Appendix B provides further details about these consultations.
- Stage 3 – Refined the Framework and developed the Implementation Plan based on findings from Stage 2; and presented the proposed Framework to the Advisory Committee in February 2018.

2 The Framework

The following chapter details the proposed Framework. It outlines key areas of focus that the Commission could report against, the potential monitoring and reporting approach, and the desired outcome of the Framework. The chapter also includes explanation of the:

- focus on people with high levels of need and/or limited access to service (section 2.1)
- social domains (section 2.2.1)
- system domains (section 2.2.2)
- outcome domains (section 2.2.3).

Reform initiatives and key areas of focus

The areas of focus identified in the Framework are key priorities in mental health and suicide prevention. At a minimum, the Commission will report against the Fifth Plan. The Fifth Plan establishes a national approach for collaborative Commonwealth, State and Territory government effort across eight targeted mental health and suicide prevention priority areas from 2017 to 2022.[3]

The Commission will also consider monitoring and reporting on the following areas of focus to the extent that the Commission is able to within allocated resources:

- **The Contributing Life Framework:** The Contributing Life Framework was first used in the Commission's 2012 National Report Card on Mental Health and Suicide Prevention. The framework spans five domains that lead to a contributing life: thriving not just surviving, effective support, care and treatment, something meaningful to do, something to look forward to, connections with family, friends, culture and community, feeling safe, stable and secure.[4]
- **The NDIS:** The NDIS is a major reform to the provision of disability services in Australia and aims to improve the lives of Australians with a significant and permanent disability and their families and carers, and to ensure people with disability receive the supports they need. Many consumers with psychosocial disabilities are eligible for support through the NDIS and ensuring that the NDIS delivers its intended benefits, and the integration of disability and mental health services is a focus of governments.

[3] The Fifth Plan can be accessed online from the Department of Health <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-fifth-national-mental-health-plan>

[4] See more online here < http://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2012-report-card.aspx

- **PHNs:** PHNs were established in 2016 to increase the efficiency and effectiveness of primary care services to patients, particularly those at risk of poor health outcomes, and to improve the coordination of care to ensure patients receive the right care at the right time. PHNs plan for, and commission mental health services; they undertake a regional approach to suicide prevention.
- **State and Territory mental health and suicide prevention plans:** each State and Territory, with the exception of the Australia Capital Territory (ACT), has mental health and suicide prevention plans that capture state and territory priorities.

The Commission's approach to monitoring and reporting

The Commission's approach to monitoring and reporting could:

- consider the reform initiatives through the lens of consumers, carers, families, and support people
- enable a whole-of-life and person-centred view
- provide a focus on groups of people in the community with high levels of need and/or limited access to services
- encompass the continuum of mental health and wellbeing
- draw attention to interface issues between sectors and services
- apply an evidence-based approach.

The Commission's desired monitoring and reporting outcome

The desired monitoring and reporting outcome describes how the Commission could measure change or improvements in mental health and suicide prevention. The desired outcome is to achieve positive change in mental health and wellbeing for all Australians, enabling people to lead a contributing life and to be part of a thriving community.

2.1 Focusing on people with high levels of need and/or limited access to service

While it is important that the proposed Framework enable monitoring of mental health and suicide prevention at a population level, additionally the Framework may provide a focus on groups of people who are at risk of mental ill health or suicidality, along with people who have unique needs and/or difficulty accessing mainstream mental health services. These population groups are described in Table 1. Reporting in this way could supplement broader monitoring and reporting on the mental health status of the general population, and consider reforms through the lens of different population groups.

Monitoring and reporting could focus on the domains of relevance to these population groups. For example, prevalence rates of suicide could be reported at a population-level, however given evidence suggesting higher rates of suicide among Aboriginal and Torres Strait Islander people, as identified as a reform priority in the Fifth plan, the Commission could report on information available around suicide rates specifically to this population group. This would similarly be the case for Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and Intersex (LGBTQI) people. Monitoring and reporting could include both quantitative and qualitative data.

Table 1: Population groups

Aboriginal and Torres Strait Islander people
Aboriginal and Torres Strait Islander mental health is a national policy priority due to its marked disparity against general population mental health. On average, Aboriginal and Torres Strait Islander people have higher exposure to mental ill health risk factors such as discrimination, racism, imprisonment and substance abuse.[5] These factors can also lead to problems of intergenerational disadvantage amongst Aboriginal and Torres Strait Islander people.[6]
Carers, families and support people for people with lived experience of mental ill health
Carers, families and support people for people with lived experience of mental ill health face unique challenges. These groups can be at risk of reduced social and economic participation due to their caring responsibilities, and can face greater risk of mental health problems.[7] It is therefore important to recognise the needs and wellbeing of carers, families and support people.

[5] The National Mental Health Commission. Contributing Lives, Thriving Communities. 2014.

[6] See the Department of Prime Minister and Cabinet's Closing the Gap reports and resources online <http://closingthegap.pmc.gov.au/>

[7] See for example Savage S, Baily S. The impact of caring on caregivers' mental health: a review of the literature. 2004.

Children and young people

Childhood health outcomes can have significant and enduring effects on a person's ongoing development and their health outcomes later in life. This is a critical period of development, noting that a first episode of psychosis is most likely to occur in late adolescence or in the early adult years.[8] It is therefore important for the Framework to monitor and report on the mental health and development of children and young people to understand how factors such as physical development, trauma and access to supports affect their outcomes. Under the Fifth Plan, the Commission will report on the following indicator: Proportion of children developmentally vulnerable in the Australian Early Development Index.

Culturally and Linguistically Diverse (CALD) communities

CALD communities include people living in Australia but born overseas in countries outside of those identified as main English speaking countries and experience diversity in language, ethnicity and culture. This may also include those who recently migrated to Australia or whose family has done so. Migration to a new culture can often create or exacerbate mental distress, including mood disorders and anxiety.[9] Furthermore, cultural and language barriers can impede a consumer's ability to navigate the mental health system, including the ability to access and receive appropriate supports.[10]

Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and Intersex (LGBTQI) people

LGBTQI people have been shown to on average have poorer mental health than the general population, including a higher risk of depression, anxiety, self-harm and suicide.[11] This is often driven by factors such as violence and discrimination which can result in and/or exacerbate mental ill health.

Older people

Older people often face changing social determinants that can negatively impact their mental health. This includes changes to employment as they transition to retirement, accompanying changes in their economic status and potential loss of social and community connections.[12]

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[8] See for example Morgan V. A., Waterreus A, Jablensky, A, Mackinnon, A, McGrath J J, Carr V, Saw, S. People living with psychotic illness 2010. 2011. Canberra, Australia: Department of Health and Ageing.

[9] Khawaja NG et al. Characteristics of culturally and linguistically diverse mental health clients. 2013.

[10] See for example Australian Institute of Family Studies. Enhancing family and relationship service accessibility and delivery to culturally and linguistically diverse families in Australia. 2008. Accessed online 15 January 2018 <https://aifs.gov.au/cfca/publications/enhancing-family-and-relationship-service-accessibility-and/barriers-service>

[11] Leonard W et al. Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians. 2012.

[12] See for example National Ageing Research Institute. Depression in older age: a scoping study. Final Report. 2009. Beyondblue.

Furthermore, older people have an increased risk of chronic physical health issues which are a risk factor for mental ill health.

People affected by domestic and family violence

Communities across Australia are affected by domestic and family violence. Domestic and family violence is recognised as a significant public health risk[13] and a major cause of mental ill health.[14] It is therefore important to consider the mental health and wellbeing of people affected by domestic and family violence, as well as the effectiveness of their support environment which aims to deliver wraparound care.

People in contact with the justice system

In 2012, almost two in five people reported a history of mental illness when entering prison.[15] This is almost double the prevalence of mental illness in the general population. People who have been in prison are significantly more likely to develop an anxiety disorder, or an affective disorder such as depression or bipolar disorder.[16]

People living in rural and remote areas

People living in rural and remote areas have different experiences of mental ill health compared to urban areas, including higher rates of suicide and higher rates of alcohol misuse.[17] This is related to social determinants such as regional economic factors and potential for social isolation due to geographical distance. Furthermore, lower levels of service accessibility in rural and remote areas can impact overall mental health outcomes.

People who are homeless

Homelessness and mental illness pose reciprocal risks. Mental health is a risk factor for homelessness due to uncoordinated services, poor support networks, social isolation and stigmatisation – one third of people with lived experience of homelessness have a severe mental

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[13] See for example the Council of Australian Government's National Plan to Reduce Violence against Women and their Children 2010-2022. 2010.

[14] See for example Access Economics. The cost of domestic violence to the Australian economy: Part 1, Violence. 2004. Office for the Status of Women, Canberra.

[15] AIHW, The health of Australia's prisoners 2012 Canberra: AIHW. 2013.

[16] For more information see the National Mental Health Commission, http://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2013-report-card/feeling-safe,-stable-and-secure/the-justice-system-and-mental-health.aspx

[17] The Royal Australian and New Zealand College of Psychiatrists. Mental health in rural areas. Accessed 25 August 2017.

illness. Conversely, the instability of homelessness can exacerbate mental illness and limit people's ability to access appropriate supports.[18]

People who misuse alcohol and drugs

Alcohol and drugs have short- and long-term effects on mental health. Short-term impacts can include anxiety, mood swings, depression, sleep problems and psychosis. Longer term impacts can result if drugs or excessive and continued alcohol consumption trigger a mental illness such as chronic depression or schizophrenia.[19]

People with an intellectual or other disability

People living with an intellectual or other disability and mental ill health often find it difficult to obtain support, as services are often provided separately for each of the co-occurring issues.[20] Without specific training, clinicians and mental health workers are unaware of the possibility of co-occurring conditions, fail to ask the appropriate questions, and create circumstances in which these individuals are either untreated, undertreated, or are treated with ineffective or inappropriate methods.

People with lived experience of serious and persistent mental ill health

People with lived experience of serious and persistent mental ill health may require multiple, concurrent supports at a higher frequency than other people who experience mental ill health, and may face higher barriers to social and economic participation due to stigma. Fragmentation of care is particularly problematic for people with lived experience of severe and persistent mental ill health who often must navigate a complex system across multiple providers.[21]

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[18] See for example Costello L et al. Mental Health and Homelessness for the Mental Health Commission of NSW. 2013. <https://nswmentalhealthcommission.com.au/sites/default/files/publication-documents/Final%20Report%20-%20AHURI%20-%20Mental%20Health%20and%20Homelessness.pdf>

[19] See for example the Drug and Alcohol Information and Support website, <http://www.drugs.ie/drugs_info/about_drugs/mental_health/>

[20] See for example Brain Injury Australia. (2007). Complexities of co-morbidity (acquired brain injury and mental ill health) and the intersection between the health and community services systems. Retrieved, 18 August, 2009, from http://www.braininjuryaustralia.org.au/docs/FaCSIA%20-%20ABI%20-%20Mental%20illness%20Dual%20DisabilityPaper-%202007_final.pdf

[21] See for example the Department of Health. Primary mental health care services for people with severe mental illness. <http://www.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/$File/4PHN%20Guidance%20-%20Severe%20mental%20illness.pdf>

Refugees and asylum seekers

Refugees and asylum seekers are at risk of the mental distress factors associated with migration, but are also likely to have experienced traumatic circumstances that further increase their risk of mental ill health.[22].

Women in the perinatal period

Women are more likely to experience mental ill health during pregnancy and the year following the birth of the child (the perinatal period), including depression and anxiety. The World Health Organization reports that in developed countries, 15.6 per cent of women experience a mental disorder during pregnancy and 19.8 per cent after child birth.[23]

Workers exposed to trauma, and/or adverse conditions in the workplace

Workers in some industries are at a higher risk of stress disorders, intentional self-harm, suicide, depression, anxiety and substance abuse than the general population.[24] This can be related to traumatic experiences they are exposed to in these roles, such as for Defence personnel, veterans, police officers, emergency services staff, and health clinicians.

In addition, workers can be exposed to adverse conditions in the workplace that impact negatively on their mental health, for example isolation, extreme fatigue or negative workplace culture that may arise for those working night shifts or fly-in fly-out working arrangements (who fly to remote locations and work long days).[25]

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[22] Li S et al. The Relationship Between Post-Migration Stress and Psychological Disorders in Refugees and Asylum Seekers. Springer Science+Business Media New York. 2016. <http://cugmhp.org/wp-content/uploads/2017/03/The-Relationship-Between-Post-Migration-Stress-and-Psychological-Disorders-in-Refugees-and-Asylum-Seekers.pdf>

[23] World Health Organization, Maternal Mental Health. <http://www.who.int/mental_health/maternal-child/maternal_mental_health/en/>

[24] See for example the National Coronial Information System. Intentional Self-Harm Fact Sheet: Emergency Services Personnel. 2015. See also Department of Veteran Affairs. Veteran Mental Health Strategy - A Ten Year Framework 2013 – 2023. Commonwealth of Australia. 2013.

[25] See for example the Western Australian Legislative Assembly Education and Health Standing Committee. The impact of FIFO work practices on mental health. 2015. http://www.parliament.wa.gov.au/Parliament/commit.nsf/(Report+Lookup+by+Com+ID)/2E970A7A4934026448257E67002BF9D1/$file/20150617 - Final Report w signature for website.htaccess

2.2 Monitoring and reporting domains

The three domain categories describe the broad areas that the Commission could monitor and report. These domain categories contain specific domains that have been chosen and prioritised based on stakeholder input as well as significant reform activities (including the Fifth Plan, the NDIS, the implementation of the PHNs, and state and territory mental health and suicide prevention plans). The domain categories are:

1. Social – the broader social factors that impact mental health outcomes of people in Australia, including social determinants and social attitudes that impact on mental health and suicide, social issues and the reform activity that is undertaken in response to these.
2. System – the performance of system activities that impact the mental health outcomes of people in Australia.
3. Outcome – the status of key mental health and wellbeing outcomes of people in Australia at both the individual and population level, and including how social context and system activities are changing these over time.

2.2.1 Social domains

Social domains are the broader social factors that impact mental health outcomes of people in Australia. They include conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.[26]

Table 2 describes focus social domains that may be monitored and reported on in the Framework over the next five years as well as additional domains that could be monitored and reported on beyond 2022. Monitoring and reporting could include both quantitative and qualitative data.

Table 2: Social domains

Focus domains for 2018 to 2022
Alcohol and drug misuse: Minimising the use of harmful substances
Excessive consumption of alcohol, use of tobacco, illicit drugs, and/or misuse of pharmaceutical drugs can impact negatively on a person's health. [27] Substance abuse can further result in increased

[26] World Health Organization, Definition of Social Determinants of Health. Accessed online 23 August 2017 <http://www.who.int/social_determinants/sdh_definition/en/>

[27] See, for example Australian Institute of Health and Welfare. Risk factors to health. 2017. Online < https://www.aihw.gov.au/reports/biomedical-risk-factors/risk-factors-to-health/contents/tobacco-smoking> Australian Bureau of Statistics. Alcohol Consumption in Australia: A Snapshot, 2004-05. Online <http://abs.gov.au/ausstats/abs@.nsf/Lookup/4832.0.55.001main+features12004-05>.

risk-taking behaviours, along with financial, health and interpersonal stressors that can negatively impact on a person's ability to live a contributing life.

Community connections: Healthy relationships with family, friends, community and culture

Healthy relationships with family, friends, community and culture create a sense of belonging. Social isolation is strongly linked to mental health issues and suicidality.[28]

Disability: A society that supports people with disability to live contributing lives

Disability status and disability type can negatively impact on a person's ability to actively engage and participate in society, as well as other aspects of health including their mental health. A society that supports people with disability to live contributing lives can improve mental health outcomes.[29]

Early childhood development and positive parenting: Getting the right start to support mental health

Many predisposing factors for mental ill health originate in childhood. Positive early childhood development and healthy family relationships build a healthy sense of identity, emotion regulation and resilience in young people, offering a protective factor against mental ill health.[30]Under the Fifth Plan, the Commission will monitor and report on the following indicator: proportion of children developmentally vulnerable in the Australian Early Development Index.

Education: Unlocking opportunities and positive mental health

Access to education provides further opportunity for more productive workforce participation. A known correlation exists between education and mental health, such that lower levels of education are associated with higher prevalence rates of mental ill health.[31] Higher levels of education (along with mentally healthy places to learn) are associated with positive mental wellbeing.[32]

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[28] Mushtaq R et al. Relationship Between Loneliness, Psychiatric Disorders and Physical Health? A Review on the Psychological Aspects of Loneliness. 2014. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4225959/>

[29] See for example the Department of Social Services, SHUT OUT: The Experience of People with Disabilities and their Families in Australia. 2012. <https://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/shut-out-the-experience-of-people-with-disabilities-and-their-families-in-australia?HTML>

[30] See for example the National Quality Standard Professional Learning Program, Health, safety and wellbeing. 2012. <http://www.earlychildhoodaustralia.org.au/nqsplp/wp-content/uploads/2012/05/NQS_PLP_E-Newsletter_No29.pdf>

[31] The World Health Organization, Risks to mental health: An overview of vulnerabilities and risk factors. 2012. <http://www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf>

[32] The World Health Organization, Department of Mental Health and Substance Abuse, the Victoria Health Promotion Foundation and the University of Melbourne. Promoting Mental Health. <http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf>

Employment: Securing and maintaining employment, and mentally healthy workplaces	
Employment impacts on a person's ability to financially support themselves and their families, and is often a significant component of a person's identity. Unemployment decreases social connectedness and financial stability, increasing the risk of mental ill health and suicidality.[33] People with lived experience of mental ill health can face barriers to gaining and maintaining paid work. Meanwhile, mentally healthy workplaces support positive mental health, while unsafe workplaces can negatively affect mental health.[34]	
Housing and homelessness: Stable and safe places to live	
Housing status and a person's living environment can impact on safety, security, employment opportunities and overall wellbeing. Housing safety and stability is particularly important for people with lived experience of mental ill health.[35] Homelessness increases a person's vulnerability and diminishes their personal security.[36]	
Justice system: A justice system that supports positive mental health and wellbeing	
Criminal activity and exposure to the criminal justice system, particularly through detention, is linked to the development and/or exacerbation of mental ill health.[37] Similarly, in some cases mental ill health can increase risk of criminal activity.[38] Victims of crime are also more at risk of mental ill health and suicidality.[39]	

[33] See for example The NHS, Unemployment and job insecurity linked to increased risk of suicide. 2015. <https://www.nhs.uk/news/mental-health/unemployment-and-job-insecurity-linked-to-increased-risk-of-suicide/>

[34] The World Health Organization, Mental Health and work: Impact, issues and good practices. <http://www.who.int/mental_health/media/en/712.pdf>

[35] Robinson E et al. Housing stress and the mental health and wellbeing of families. 2008. <https://aifs.gov.au/cfca/publications/housing-stress-and-mental-health-and-wellbeing-famili>

[36] AIHW. Vulnerable young people: interactions across homelessness, youth justice and child protection: 1 July 2011 to 30 June 2015. 2016.

[37] Freedman D et al. Neighborhood Effects, Mental Illness and Criminal Behavior: A Review. 2014. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4169988/>

[38] Mulvey EP. Assessing the evidence of a link between mental illness and violence. <https://www.ncbi.nlm.nih.gov/pubmed/7927290>

[39] See for example The National Center for Victims of Crime, Mental Health Consequences of Crime. <https://victimsofcrime.org/docs/Parallel%20Juctice/PJ-MENTAL%20HEALTH%20CONSEQUENCES%20OF%20CRIME.pdf?sfvrsn=0>

Physical health: Looking at the whole person

The reciprocal relationship between more severe and persistent mental illness and poor physical health, including cardiovascular disease and diabetes, is increasingly clear. Consequently, the physical health care of people with lived experience of severe and persistent mental illness has been identified as a serious public health challenge.[40]

Stigma and social discrimination: Breaking down the barriers to acceptance and help

Social stigma and discrimination can make mental ill health worse, make it harder to recover from mental health problems, and/or stop a person from getting the help they need. It may cause the person to avoid getting the help they need, due to fear of stigmatisation.[41] Under the Fifth Plan, the Commission will monitor and report on the following indicator: Experience of discrimination amongst people with lived experience of mental illness.

Additional domains beyond 2022

Economic: Having the means to live a contributing life

Economic security is fundamental to an individual's ability to lead a contributing life. The effects of economic uncertainty can be seen at the population level, where access to health and social services may be impacted by broader macroeconomic trends. It may also be viewed from the micro perspective, where a person living with mental ill health may be unable to participate fully in employment, both limiting their economic engagement and producing ongoing barriers to recovery and a stable occupation.[42]

Technology and e-mental health: Connecting and supporting online

Technology and social media have changed the way people communicate and connect. The extent to which this impacts on mental health and suicide is yet to be fully determined, but there is an increase in research in this space.[43] While the digital environment provides opportunities for people to connect and engage with services, it has also acted as a disruptor for mental health service

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[40] For more information see the National Mental Health Commission, Equally Well. <https://equallywell.org.au/>. See also Mental Health Commission of NSW (2016). Physical health and mental wellbeing: evidence guide, Sydney, Mental Health Commission of NSW. <https://nswmentalhealthcommission.com.au/sites/default/files/publication-documents/Physical%20health%20and%20wellbeing%20-%20final%208%20Apr%202016%20WEB.pdf>

[41] Corrigan P et al. The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care. 2014. <http://journals.sagepub.com/stoken/rbtfl/dDpyhM2zRi.Fg/full>

[42] McDaid D et al. Employment and mental health: Assessing the economic impact and the case for intervention. 2008. < http://eprints.lse.ac.uk/4236/1/MHEEN_policy_briefs_5_Employment(LSERO).pdf>

[43] Luxton D et al. Social Media and Suicide: A Public Health Perspective. 2012. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3477910/>

delivery. For example, counselling services can now be offered online as well as over the phone or face to face.[44]
Violence, trauma and neglect: Recovering mentally
Violence, trauma and neglect can result in short- and long-term effects on mental health. These can include depression, Post-Traumatic Stress Disorder, and Complex Trauma.[45]

2.2.2 System domains

System domains cover the performance of health and social services that impact mental health outcomes of people in Australia. For the purposes of the proposed Framework, the term 'system' describes the activity of all organisations and resources used to provide care and support to improve the mental health and wellbeing for people in Australia.[46] This includes relevant organisations and resources in the broader Australian health and social services systems, given the highly interrelated nature of mental health with broader health and social determinants.

System performance spans a range of different support types. Importantly, it examines activities in all settings (including acute care, primary care, community-based care, and social services), and activities delivered across service providers (public supports, private supports, and non-government sector supports). The proposed Framework enables monitoring and reporting of the following activities:

- **Promotion, prevention and early intervention** – including educational awareness programs and early intervention supports.
- **Primary health care** – including general practice and community health.
- **Community based supports** – including community-based care provided by state and territory managed services and the non-government sector.
- **Social service supports** – including housing services, employment services, disability support services, and services related to the justice system.
- **Residential mental health services** –including specialised mental health care provided on an overnight basis in a domestic-like environment.

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[44] See for example the National Institute of Mental Health, Technology and the Future of Mental Health Treatment. <https://www.nimh.nih.gov/health/topics/technology-and-the-future-of-mental-health-treatment/index.shtml>

[45] Substance Abuse and Mental Health Services Administration. Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioral Health Services. 2014. <https://www.ncbi.nlm.nih.gov/books/NBK207201/>

[46] Adapted from the following definition: World Health Organization. Assessment Instrument For Mental Health Systems, p. 10. 2005.

- **Hospital supports** – specialised mental health care delivered in public and private psychiatric hospitals, psychiatric units or wards in public admitted hospitals, and outpatient services.
- **Private health supports** – including office-based supports such as private psychiatry and psychology.

The proposed Framework includes system domains to provide a comprehensive picture of how the Australian system performs in response to mental health and suicide. Monitoring and reporting could include both quantitative and qualitative data. Each of these domains is described in Table 3.

Table 3: System domains

Focus domains for 2018 to 2022

Accessibility and equity: Timely access to care for all

Accessibility and equity refers to the system's ability to provide all people in Australia with the supports they need, when they are needed, irrespective of factors such as income, geography and cultural background. This is important to ensure timely and proactive care for people.
Under the Fifth Plan, the Commission will report on:

- population access to mental health care.

This domain also includes:

- the availability of mental health and relevant social service supports across different geographical regions and demographics
- waiting times for people to access mental health and relevant social service supports
- the proportion of people who have difficulty accessing mental health and relevant social service supports
- changes to the availability of supports to people with psychosocial disabilities due to the implementation of the NDIS
- the extent to which any difficulty accessing services can be attributed to a measure such a geographical location, ethnicity, gender, religion etc.

Consumer and carer participation and leadership: A system shaped by people with lived experiences

Consumer and carer participation and leadership refers to the representation of consumers and carers at all levels of the system, including policy development, service planning, delivery, evaluation and research. This domain supports a person-centred system that is shaped by people with lived experience of mental ill health and suicidality. Under the Fifth Plan, the Commission will report on:

- the proportion of total mental health workforce accounted for by the mental health peer workforce.

This domain also includes:

- consumer and carer reported measures of involvement in care planning and decisions
- the representation of consumers and carers in the senior governance of service provider organisations
- the engagement of consumers and carers in policy development
- the presence of consumer and carer feedback mechanisms for providers of care.

Continuity and integration of care: Seamless care throughout each consumer's journey

Continuity and integration of care refers to the system's ability to seamlessly support consumers across different kinds of care throughout their journey. This ensures consumers can 'step up' and 'step down' to the supports that suit their changing needs, whether this includes primary care, community-based care, social services, hospital care, private care, or care from the non-government sector. Continuity is also important to ensure a cohesive experience of care from the consumer's perspective. Under the Fifth Plan, the Commission will report on the following indicators:

- post-discharge community care
- readmission to hospital
- rates of follow-up after suicide attempt/self-harm.[47]

This domain also includes:

- the prevalence of mental health recovery plans that promote continuity and integrated care
- private psychiatrist and General Practitioner consultations following public or private hospital discharge
- the proportion of admitted consumers who have received pre-admission care.

Safety, quality and responsiveness: Care that follows best practice and puts consumers first

Safety, quality and responsiveness refer to the system's ability to provide care that minimises the risk of harm, is relevant to the consumer's needs, upholds the dignity of consumers, and demonstrates best practice. Under the Fifth Plan, the Commission will report on the following indicators:

- rate of seclusion in acute inpatient mental health units
- rate of involuntary hospital treatment
- suicide of persons in inpatient mental health units.

This domain also includes:

[47] This refers specifically to presentations to hospital that are followed up in the community within an appropriate period.

- the prevalence of incidents that result in harm to consumers of mental health and social services
- levels of accreditation against national mental health standards
- the prevalence of suicide in mental health care
- the extent of transparency of service provider performance and the degree to which service providers report measures to improve performance based on feedback
- the prevalence of the use of restraint
- the prevalence of prescription drug use
- the provision of gender specific wards.

Sustainability, capability and funding: A sustainable system equipped to care for people

Capability and funding refers to whether the system has appropriate capabilities and funding to respond to emerging needs and ensure quality services can be provided in the long term. This domain includes:

- the level of funding for mental health and social service supports, and how this changes over time
- the capability levels of the mental health and relevant social service workforces
- the level of investment in workforce training
- the impact of provider incentives on the market (e.g. encouragement of new entrants into the market, maintenance of market stability)
- the performance of service provider enablers such as systems and technology
- the strength of service provider governance mechanisms (including mental health clinical governance), the level of investment in mental health research (including research translation) and innovation.

Additional domains beyond 2022

Efficiency: Providing value for money for society

Efficiency refers to the system's ability to achieve desired outcomes with the most cost-effective use of resources. This ensures the system extracts the maximum value from funding inputs, and can keep the cost of service provision low. This domain includes:

- technical efficiency of provision (across both hospital and community care)
- the average cost of supports (across both hospital and community care).

Environment and design: Delivering care in appropriate environments
Environment and design refers to the safe environment and design of mental health service delivery locations. The architectural design of mental health facilities, including its technology and equipment, influences patient safety and service performance. This domain includes: • whether factors influencing the built environment (e.g. patient-centeredness, safety, equity) are considered in planning and design of mental health service delivery locations • the level of innovation.
Legislation: Highlighting consistency and coordination across Australia
Legislation refers to Commonwealth and State and Territory legislation. This domain includes: • legislation that is appropriate for people with lived experience of mental ill health • legislation that is consistent between different jurisdictions • the level of investment in coordination of legislation.
Research: Using evidence as a catalyst for change
Research is an important driver for reform in the mental health sector and related social services, as reflected in the Fifth Plan action to develop a research strategy. This domain includes: • the level of investment in mental health research and innovation • levels of collaboration and coordination in mental health research • the presence and impact of the planned Fifth Plan research strategy • the strength of policy translation.
Workforce: A skilled workforce to provide services to people with lived experience of mental ill health, carers, families, and support people
Workforce refers to the mental health workforce, including peer workers. Under the capability domain discussed above, the capability of the workforce could be a priority for monitoring and reporting over the 2018-2022 period. However, this is only one element of the workforce. This domain covers workforce more broadly and includes: • the capability of the workforce to provide evidence based, person-centered, and trauma informed care for the people with lived experience of mental ill health • building a qualified, supported and appropriately funded peer workforce • the planning and distribution of services and workforce based on community needs.

2.2.3 Outcome domains

Outcome domains are the impacts of social contexts and system performance, and reflect the key mental health and wellbeing outcomes of people in Australia at both the individual and population level. They measure whether people lead a contributing life and are part of a thriving community. Monitoring and reporting could include both quantitative and qualitative data. Each of these focus domains is described in Table 4.

Table 4: Outcome domains

Focus domains for 2018 to 2022
Broader quality of life outcomes: Thriving, not just surviving
This domain measures the broader factors that support a contributing life for people who experience mental ill health and suicidality in Australia. It is important for the proposed Framework to capture these quality of life factors to enable a broader understanding of health and wellbeing from the consumer's perspective. Future monitoring and reporting could be supported by the new Living in the Community Questionnaire, which covers several aspects of a contributing life. Under the Fifth Plan, the Commission will report on the following indicators: • rate of drug use in people with mental ill health • avoidable hospitalisations for physical illness in people with mental ill health • connectedness and meaning in life • rate of social/community/family participation amongst people with mental ill health • proportion of people with mental ill health in employment • proportion of carers of people with mental ill health in employment • proportion of mental health consumers in suitable housing. This domain also includes: • the proportion of people in prison with mental ill health • the prevalence of alcohol and tobacco abuse amongst people with mental ill health • the presence of comorbid chronic physical health conditions of people with mental ill health.
Mental health outcomes: Improving the mental health and wellbeing of people with lived experience
This domain measures the mental health outcomes for people in Australia who experience mental ill health or suicidality. Monitoring and reporting on this domain could be supported by the roll out of the Your Experience of Service (YES) survey, which includes a range of patient-reported

experience measures (PREMs) as well as several patient-reported outcomes measures (PROMs).[48] [49] Under the Fifth Plan, the Commission will report on the following indicators:

- long-term health conditions in people with mental ill health
- the mortality gap for people with mental ill health (which refers to average life expectancy compared to the broader population)
- proportion of consumers and carers with positive experiences of service provision
- changes in the mental health consumers' clinical outcomes.

This domain also includes:

- the proportion of consumers who report PROMs
- the outcomes relating to specific conditions (e.g. bipolar disorder)
- mental health outcomes for people with mental ill health and psychosocial disabilities
- the impact of early years interventions and their impact on future life outcomes
- the mortality rate of people with mental ill health (compared to the broader population).

Prevalence of diagnosable mental ill health, suicide and suicide attempts: Building a mentally healthy population

This domain measures the number of people in Australia who have diagnosable mental ill health, or experience of suicidality, and the population rates of suicide. Many measures of mental ill health prevalence are not regularly updated. Despite this, it is important for the Framework to consider prevalence to understand the extent of mental ill health and suicidality in Australia. Under the Fifth Plan, the Commission will report on the following indicators:

- prevalence of mental ill health
- proportion of adults with very high levels of psychological distress
- rates of suicide.

This domain also includes:

- the prevalence of high need, low prevalence disorders
- the prevalence of high prevalence disorders

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[48] Mental Health Services in Australia, AIHW. YES survey – sample survey instrument. Accessed September 2017 from https://mhsa.aihw.gov.au/committees/mhissc/YES-survey/

[49] PROMs are used to help assess and follow up a patient's clinical progress. PREMs help to assess the patient's experience of health care. For more information see NSW Agency for Clinical Innovation. Patient Reported Measures. Accessed online 15 January 2018 < https://www.aci.health.nsw.gov.au/make-it-happen/prms>

- the prevalence of self-reported positive mental health and wellbeing
- the rates of attempted suicide
- the prevalence of self-harm.

Additional domains beyond 2022
Mental health literacy: A growing understanding of positive mental health and wellbeing
Mental health literacy refers to the knowledge and skills required to promote positive mental wellbeing including the ability to recognise, manage and prevent mental illness. This domain includes: • resilience and emotion regulation skills • recognising and understanding mental illness and how to best care for themselves • knowledge of best available help and ability to access this.
Positive wellbeing in the community: Thriving and supportive communities
Positive wellbeing is strongly linked to quality of life and life satisfaction. This domain includes: • the level of community connectedness • resilience • social support.

3 Implementation roadmap for 2018 to 2022

The following section describes the roadmap for how the Commission could monitor and report on mental health and suicide prevention from 2018-2022. This includes:

- flexible reporting (section 3.1)
- the cycle of reporting (section 3.2)
- implementation, including data sources, analysis and stakeholder collaboration (section 3.3).

3.1 Flexible reporting

The Commission could use a range of flexible monitoring and reporting formats to convey compelling messages about mental health and suicide prevention in Australia. To achieve this, the Commission's reports could be communicated with the five principles described in Figure 3.

Figure 3: Potential flexible reporting principles

Flexible reporting principles

- Uses data and stories to tell a narrative that is centred around consumers, carers and families
- Easy to understand and uses plain language for people of all levels of knowledge
- Visual and engaging, including through online interactivity
- Responsive to accessibility requirements such as technology, language and literacy barriers
- Provides succinct summaries but also enables readers to 'drill down' to find further detail

To achieve positive change in mental health and wellbeing for all Australians, the Commission's monitoring and reporting could aim to target a diverse range of audiences with different needs and interests. These audiences include:

- consumers
- carers, families, and support people
- service providers and the mental health workforce
- policy and decision makers
- academics and researchers
- the public.

To successfully meet the information needs of these diverse audiences, the Commission could draw from a range of traditional and digitally-enabled formats. These formats vary in terms of purpose, intended audience, content, presentation and frequency, and are described in Table 5.

The Commission could also at times engage in **multi-format reporting** to convey the same insights to a range of stakeholders. For example, the Commission may release a range of smaller reports alongside an annual report (such as a media release, snapshot report, visual media and links to source data) to reinforce the insights of the annual report and reach a wider range of audiences.

Table 5: Monitoring and reporting formats

Format	Why - purpose	What - content	Who – primary audience	How - presentation	When - frequency
Annual reports	Provides consolidated and detailed findings on a broad range of national topics	• Progress against a broad and consistent set of national indicators, including the Fifth Plan indicators • Qualitative and quantitative analysis on policy-relevant topics • Analysis and comparison of different jurisdictions	• Government policy and decision makers • Academics • Service providers	• Detail is presented through plain language text and supported by visuals, charts and infographics • Online Portable Document Format (PDF) report as well as an interactive micro site[50]	Released annually
Focus reports	Provides a 'deep dive' analysis of a specific topic	• Detailed quantitative and qualitative analysis of a topics relating to mental health and suicide prevention	• Government policy and decision makers • Academics • Service providers	• Detail is presented through text, but supported by visuals, charts and infographics • Online PDF report	Released annually, off cycle to the annual report

[50] In this context, 'micro site' is a website completely dedicated to a report. See, for example, the Salvation Army's 2016 Annual Report at www.salvationarmyannualreport.org/

Format	Why - purpose	What - content	Who – primary audience	How - presentation	When - frequency
Snapshot reports	Provides a short and visually engaging summary of a topic, or a quick summary of another longer report (for example, an annual report) for time-poor readers	• Clear and short messages on a specific topic, or key summary points from another longer report	• Government policy and decision makers • Academics • Service providers • The public • Media • Service providers	• Minimal plain text supported by visuals, charts and infographics • Online PDF report or web page	Released in conjunction with core reports or to highlight topical issues
Visual media (including infographics, animations, and videos)	Communicates insights in a visually engaging way that is easy to share through social media	• Memorable facts and statistics that can aid public awareness and be shared by the media • Case studies and personal stories that can be conveyed through videos	• The public • Media	• Visually engaging and simple, so that information can be quickly digested • Presented to maximise sharing through social and online media	Released in conjunction with core reports or to highlight topical issues

Format	Why - purpose	What - content	Who – primary audience	How - presentation	When - frequency
Interactive data	Allows users to interact with data through a web interface to customise their data needs	• Quantitative information that can be analysed through different filters	• Media • Government policy and decision makers • Academics • Service providers • The public	• Intuitive and flexible web interface through which the user can create their own data tables and charts	Released in conjunction with core reports or to highlight topical issues
Links to source data	Allows users to easily access source data on topics that interest them	• Embedded hyperlinks in online reports to source data that is owned and hosted by other organisations	• Government policy and decision makers • Academics • Service providers	• Embedded hyperlinks throughout reports and in bibliographies	Included in all online reports
Media releases	Overviews key information in the form of a succinct briefing	• Key facts and messages about mental health and suicide, important events in the mental health sector, or about the Commission itself.	• The public • Media • Government policy and decision makers • Service providers	• Short, plain text briefing posted to the Commission's website and shared on social media where appropriate	Released in conjunction with core reports or to highlight topical issues

3.2 Cycle of reporting

The Commission could consider developing a planned calendar of reporting for each year that could draw from the variety of formats discussed in section 3.1. The reporting calendar for each year could be planned to best meet the needs of the Commission's stakeholder as well as to balance internal resourcing considerations. Figure 4 overleaf describes an example reporting cycle for a calendar year.

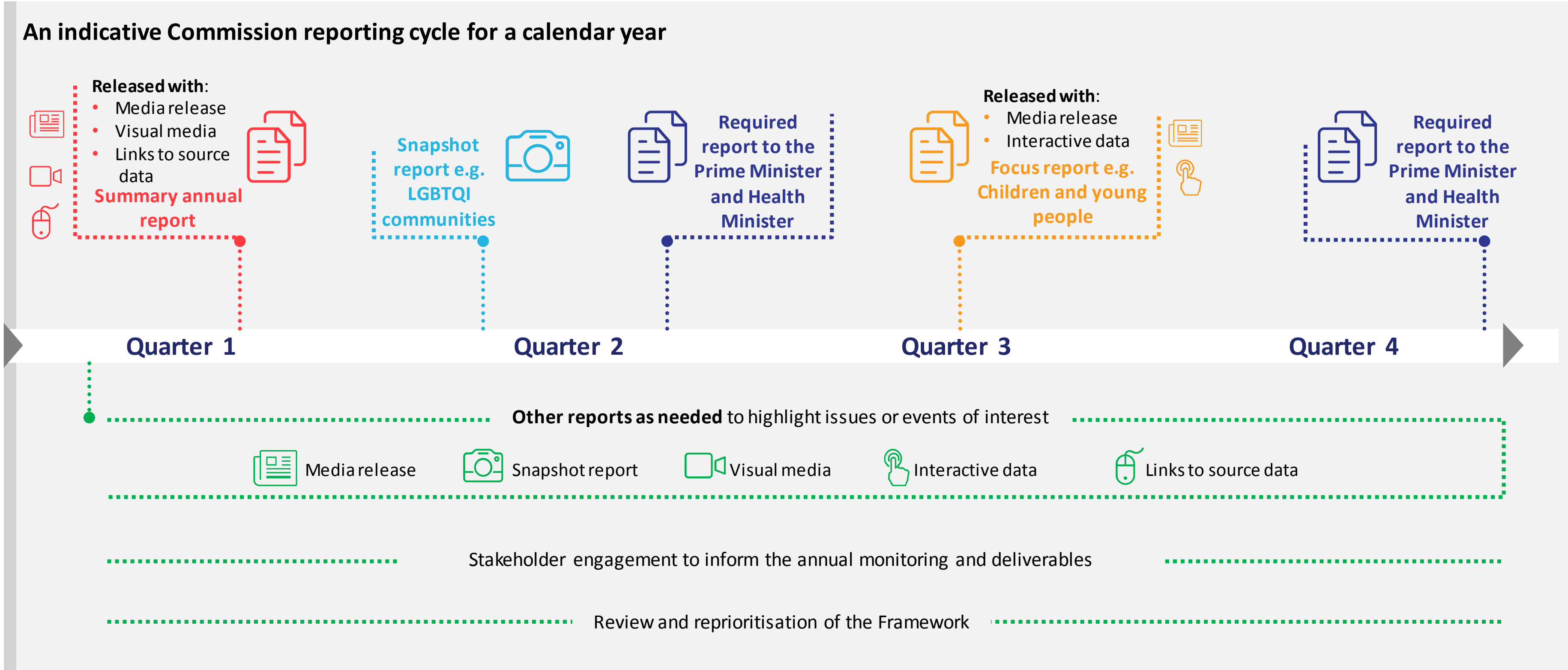
The Commission's cycle of reporting could be underpinned by three activities:

1. **Stakeholder consultation to inform annual monitoring and reporting deliverables:** Consultation could inform the content of the Commission's reports, as well as the timing and formats of reports. Section 3.3.3 provides further detail on how the Commission could collaborate with its various stakeholders.
2. **Review of the monitoring and reporting focus areas:** The Commission could review its monitoring and reporting deliverables annually as the needs of its stakeholders, policy and reform priorities and the mental health and suicide prevention reporting environment changes.
3. **Reviewing the Framework in 2022:** The Commission could formally review the Framework during 2022, and make updates where required to guide monitoring and reporting from 2023 onwards.

The Commission could publish a reporting calendar on its website. This allows report audiences to plan and use the released information most effectively. This reporting calendar could also assist the Commission to proactively plan resourcing and consultation to inform planned reports on specific topics.

The reporting cycle could be staggered depending on the size of the different report, and each report will not necessarily be released in the same calendar year as its commencement.

Figure 4: Indicative reporting cycle for a calendar year



3.3 Implementation

The following section describes how the Commission could implement the Framework, including:

- domain data sources and reporting frequency (section 3.3.1)
- opportunities for analysis (section 3.3.2)
- stakeholder collaboration (section 3.3.3).

3.3.1 Domain data sources and reporting frequency

The frequency at which the Commission monitors and reports quantitative data on each domain depends on its relative priority and the availability of relevant data sources. Table 6 (overleaf) describes the focus domains for 2018-2022, specific topics of interest within each domain, and the expected frequency of reporting based on available data sources.

The expected frequency of reporting is based on currently available data, and is expected to change as further data developments are undertaken. Additionally, as is discussed in section 3.3.2, different analytical approaches have the potential to enable more frequent or more effective reporting on different domains.

Table 6: Domain data sources

Category	Focus domains	Reason for prioritisation	Topics of interest within the focus domain	Data sources and expected frequency of reporting over next five years
Social	**Alcohol and drug misuse:** Minimising the use of harmful substances	• Contributing Life Framework	• Alcohol dependence and harmful use • Illicit drug use	These social domains cover broader social factors that impact mental health outcomes of people in Australia, including social determinants and social attitudes that impact on mental health and suicide, social issues and the reform activity that is undertaken in response to these. Data sources are the same across several areas in the different domains. Monitoring and reporting against these domains could include: • baseline reporting of data and summary evidence about the impact of the domain on mental health and suicide prevention • information about community attitudes and understanding • significant policy and reform activity and major expenditure initiatives at Commonwealth, State and Territory level relevant to the domain • the proportion of people with lived experience of mental illness who report the use of licit and illicit drugs through the National Drug Strategy Household Survey, conducted every three years and most recently in 2016 evidence and case studies highlighting effective interventions relevant to the domains. Data sources to establish the baseline include the National Health Survey, the National Drug Strategy Household Survey, the General Social Survey, the Australian Early Development Census, the Living in Community Questionnaire. The Commission may also monitor and report on whether governments have negotiated agreements that prioritise coordinated treatments and supports for people with lived experience of severe and complex mental illness,
	Community connections: Healthy relationships with family, friends, community and culture	• Fifth Plan • Contributing Life Framework	• Community, social and personal connections including through digital communities and online forums	
	Disability: A society that supports people with a disability to live contributing lives	• Contributing Life Framework • NDIS	• Supportive social attitudes towards disability	
	Early childhood development and positive parenting: Getting the right start to mental health	• Contributing Life Framework • PHN	• Positive early childhood development	
	Education: Unlocking opportunities and positive mental health	• Contributing Life Framework	• Mentally healthy schools • Early childhood • Tertiary education settings	
	Employment: Securing employment and mentally	• Contributing Life Framework	• Small to medium businesses	

Category	Focus domains	Reason for prioritisation	Topics of interest within the focus domain	Data sources and expected frequency of reporting over next five years
	healthy workplaces		• Welcoming workplaces	including planning for the community mental health support needs of people who do not qualify to receive supports under the NDIS. The Commission may also monitor the government's commitment in the Fifth Plan to reduce stigma and discrimination in the health workforce. For example, the Commission could monitor and report on the number of training programs that have been developed and implemented to build awareness of and knowledge about the impact of stigma and discrimination. It could monitor and report on the development of the Peer Workforce Development Guidelines in line with Priority 8 of the Fifth Plan. The cycle of reporting for individual domains could be determined by the process outlined in section 3.2 of the report. Significant policy and reform activity and major expenditure initiatives could be reported on annually, with their impact for people with lived experience of mental ill health and on suicide being reported against the outcome domains.
	Housing and homelessness: Stable and safe places to live	• Fifth Plan • Contributing Life Framework • NDIS	• Availability of appropriate housing • Integration of mental health and housing services	
	Justice system: A justice system that supports positive mental health and wellbeing	• Contributing Life Framework	• Availability of mental health support in the justice system • Juvenile justice • Justice reinvestment	
	Stigma and social discrimination: Breaking down the barriers to acceptance and help	• Fifth Plan • Contributing Life Framework	• Community perceptions of mental health • Experiences of discrimination	
System	**Accessibility and equity:** Timely access to care for all	• Fifth Plan • Contributing Life Framework • NDIS • PHN	• Access to mental health care and social service supports in regional and remote areas (Fifth Plan) • Changes to accessibility due to the NDIS • Access to mental health care through private health insurance	**Some indicators to be reported annually; Others likely to remain gaps over next five years.** Annual data on access to mental health care can be sourced from the Medicare Benefits Scheme (MBS), Private Psychiatric Hospitals Data Reporting and Analysis Service, the Department of Veterans Affairs and state and territory health departments. This covers a large proportion of the system. Data on changing accessibility due to the implementation of the NDIS may be available through the National Disability Insurance Agency (NDIA). Data on access to social services may be available through the Department of

Category	Focus domains	Reason for prioritisation	Topics of interest within the focus domain	Data sources and expected frequency of reporting over next five years
			• Access to primary mental health services • Unmet need for mental health care and social services	Human Services and Department of Social Services.
	Sustainability, capability and funding: A system equipped to care for people	• Fifth Plan • NDIS • PHN	• Expenditure on support for people with mental ill health and at risk of suicide through specialised and other health and community services • The size and capability of the mental health and social services workforces	**Indicators to be reported annually.** Expenditure on state and territory funded specialised mental health services is collected annually by the Australian Institute of Health and Welfare (AIHW) though the Mental Health Establishments National Minimum Data Set. Commonwealth expenditure on identified mental health services and psychotropic medication is available annually through MBS, Pharmaceutical Benefits Scheme (PBS), and other data sources, for example the AIHW Mental Health Services in Australia report. The data sources and availability of expenditure information on other health and social services varies according to different services. Information on the mental health workforce is included in the National Health Workforce Data Set that which is updated by the Australian Health Practitioners Regulation Agency annually, and reported on by AIHW. The data sources and availability of information on social services workforces varies for different types of social services due to different renewal cycles, for example.
	Consumer and carer participation and leadership: A system shaped by people with lived experience	• Fifth Plan • Contributing Life Framework	• Participation in the mental health peer workforce (Fifth Plan) • Consumer and carer involvement in care planning and treatment decisions (Fifth Plan)	**Indicators to be reported annually.** The number of peer workers in state and territory services is measured annually in the Mental Health Establishments National Minimum Data Set. Further data on consumer and carer participation will become available through the YES survey and the Mental Health Carer Experience Survey.
	Continuity and integration	• Fifth Plan	• Integration of primary mental health care with	**Some indicators to be reported annually; Others likely to remain gaps over next five years.**

Category	Focus domains	Reason for prioritisation	Topics of interest within the focus domain	Data sources and expected frequency of reporting over next five years
	of care: Seamless care throughout each consumer's journey	• Contributing Life Framework • NDIS • PHN	other types of care (Fifth Plan) • Integration of mental health care and disability supports • Integration of e-mental health care with other types of care • Integrated regional service planning	Some data on continuity of care can be accessed annually from state and territory clinical mental health data systems. However, there are gaps for private and non-government services, the integration between health and social services and for some key indicators (e.g. rates of follow up after suicide attempt/self-harm). The Commission can monitor and report on government support for integrated planning and service delivery at the regional level as an action under the Fifth Plan. For example, the Commission could monitor and report on government requirements to develop and publicly release joint regional mental health and suicide prevention plans, and the development and release of planning tools based on the National Mental Health Suicide Prevention Framework and an evidence based, stepped care model.
	Safety, quality and responsiveness: Care that follows best practice and puts consumers first	• Fifth Plan • Contributing Lie Framework	• Person-centred care (Fifth Plan) • Suicide of persons in inpatient mental • Involuntary hospital treatment (Fifth Plan) • Care that upholds the dignity and rights of consumers (Fifth Plan) • Stigma in the context of service provision (Fifth Plan)	**Some indicators to be reported annually; Others likely to remain gaps over next five years.** Seclusion and restraint indicators will be able to be reported annually using the National Seclusion and Restraint Data Collection. Involuntary hospital treatment can be reported annually using the National Hospital Morbidity Database. Involuntary treatment in residential care can be reported using the National Residential Mental Health Care Database, and involuntary treatment in the community can be reported using National Community Mental Health Care Database. Some indicators will be able to be reported annually using state and territory data (e.g. the rates of suicide in inpatient mental health units) or the National Seclusion and Restraint Data Collection. Other indicators will be considered once the NDIS Quality and Safeguards Commission (NDIS QSC) has been established to implement the NDIS Quality and Safeguarding Framework. The Commission may also monitor and report on the Australia Government's commitment to develop a National Mental Health Safety and Quality Framework that guides the delivery of the full range of health and support services required by people living with mental illness. It may also monitor and report on the development of a mental health supplement to the National

Category	Focus domains	Reason for prioritisation	Topics of interest within the focus domain	Data sources and expected frequency of reporting over next five years
				Safety and Quality Health Service (NSQHS) Standards (second edition), and the implementation of the YES survey tool. It may monitor and report on the consistency across jurisdictions in mental health legislation, and whether governments have made accessible the WHO Quality Rights guidance and training tools to build awareness amongst consumers and carers.
Outcomes	**Broader quality of life outcomes**: Thriving, not just surviving	• Fifth Plan • Contributing Life Framework • NDIS	• Physical health outcomes (Fifth Plan) • Mental health consumers and carers in employment (Fifth Plan) • Alcohol and drug misuse (Fifth Plan) • Connectedness and meaning in life (Fifth Plan) • Mental health consumers in suitable housing (Fifth Plan) • Experiences of discrimination (Fifth Plan) • Positive early childhood development (Fifth Plan) • Educational outcomes • Justice system outcomes • Supportive social attitudes towards	**Indicators largely expected to be reported every 2-3 years, though this varies by indicator.** The frequency of each indicator will be determined by data availability, for example: • physical health data and employment outcomes data can be reported every three years (National Health Survey) • drug use can be reported every three years (National Drug Strategy Household Survey) • social participation and experience of discrimination can be reported approximately every four years (General Social Survey, last conducted in 2014) • early childhood development can be reported every three years (Australian Early Development Census) educational outcomes can be reported through the Australian Child and Adolescent Survey of Mental Health and Wellbeing (note this has only been conducted twice over a 16-year period, and most recently in 2014) • the self-reported mental health of Australian prisoners and dischargees is reported in the AIHW National Prisoner Health Data Collection (conducted four times, most recently in 2015) There are also some information gaps that constrain monitoring and reporting which are likely due to methodological issues (including information on avoidable hospitalisations for physical illness, educational outcomes and employment outcomes).

Category	Focus domains	Reason for prioritisation	Topics of interest within the focus domain	Data sources and expected frequency of reporting over next five years
			disability	The Living in the Community Questionnaire (developed in 2016) provides more data on broader quality of life outcomes (including housing and homelessness). If it is feasible to be implemented in mental health services, then in the long-term, data will become available on the proportion of mental health consumers reporting connectedness and meaning in life.
	Mental health outcomes: Improving the mental health and wellbeing of people with lived experience	• Fifth Plan • Contributing Life Framework • NDIS • PHN	• Positive experiences of care (Fifth Plan) • Changes in both clinical and patient-reported outcomes (Fifth Plan) • Mortality gap for people with mental illness (Fifth Plan) • Mental health outcomes for people with psychosocial disabilities	**Clinical outcomes from state/territory services to be reported annually; Other outcome indicators may remain gaps over next five years.** Clinical outcomes indicators for state/territory services can be measured annually through the National Outcomes and Casemix Collection (NOCC). The NOCC includes a range of clinician-rated and consumer-rated outcome measures. Other outcomes data is still in development. Consumer-reported outcomes data will be partially supported in future by the roll out of the YES survey which includes a small number of outcomes measures. Other gaps that are likely to persist in the near future include data on non-government organisations and information on the mortality of people with mental illness (which requires a standard measurement methodology to be used across jurisdictions.
	Prevalence of diagnosable mental ill health, suicide and suicide attempts: Building a mentally healthy population	• Fifth Plan • Contributing Life Framework	• Prevalence of suicide and self-harm (Fifth Plan) • Prevalence of mental illness (Fifth Plan) • Prevalence of high levels of psychological distress (Fifth Plan)	**Rates of suicide to be reported annually; Mental illness prevalence data to remain unavailable over next five years.** Suicide data is available annually from the Australian Bureau of Statistics (ABS) Causes of Death data. However, there are complexities surrounding accurate identification of suicide, and data gaps for attempted suicides. Population-wide mental illness prevalence data has been captured to an extent in the National Survey of Psychotic Illness 2010, and the Australian Child and Adolescent Survey of Mental Health and Wellbeing 2013. However, population-wide mental illness prevalence data is perceived by many stakeholders as a major gap, as it has not been representatively and rigorously gathered since the 2007 National Survey of Mental Health and Wellbeing. As a result, there is no conclusive evidence to suggest whether

Category	Focus domains	Reason for prioritisation	Topics of interest within the focus domain	Data sources and expected frequency of reporting over next five years
				population prevalence moves substantially year to year, and the Commission may wish to use other data sources as proxies over the next five years (e.g. the National Health Survey measures prevalence of high psychological distress in adults, and is conducted every three years). Additionally, the Commission could initiate the development of data sources to measure low prevalence disorders, where current data is not available such as eating disorders and personality disorders, given their levels of chronicity and associated impairments.

3.3.2 Opportunities for analysis

Through research and consultation, four opportunities for monitoring and reporting analysis were identified where the Commission could add value to the sector:

1. The Commission is not a primary data collection agency and could focus on sourcing data from others, but may incrementally explore opportunities to use primary data.
2. The Commission could draw together qualitative and quantitative data to support more detailed analysis than available in current monitoring and reporting.
3. The Commission could analyse and compare data at national, jurisdictional and sub-jurisdictional levels, where possible.
4. The Commission could use its monitoring and reporting role to highlight data gaps, and could inform data development and data linkage efforts in the sector.

These opportunities are described in further detail below.

1. The Commission is not a primary data collection agency and could focus on sourcing data from others, but may incrementally explore opportunities to use primary data

The Commission does not have the resources and infrastructure to be a primary data collector or custodian of large data sets. The Commission could draw on data that is collected by other organisations. The Commission could therefore build relationships and collaborate closely with states and territories, other organisations and data custodians in the sector to ensure relevant and high-quality data is able to inform monitoring and reporting.

There may be targeted opportunities for the Commission to pursue primary data sources rather than accessing data through other organisations. These opportunities include:

- Social media data (for example, information on consumer and carer support communities on Facebook).
- Google search analytics (for example, the types of mental health services that are searched for on Google, the frequency of enquiries for, and use of, online e-mental health services and the characteristics of people using online services).
- Surveys for consumers and carers (for example, surveys distributed through the Commission's website and through consumer and carer forums).

The extent to which social media, internet and other digital data can be used effectively for mental health and suicide monitoring and reporting in Australia is largely untested. However, given the potential to draw on lived experience and access information about online treatment and self-help use, the Commission may consider piloting monitoring and reporting using this data.

2. The Commission could draw together qualitative and quantitative data to support more detailed analysis than available in current monitoring and reporting

Most data analyses in the current monitoring and reporting landscape focus on quantitative data. The Commission recognises the value in both quantitative and qualitative data, and that the combination of both data types can result in rich, evidence-based storytelling. Therefore, the Commission could use both quantitative and qualitative data in its reporting.

The Commission has opportunities to use new sources of qualitative data. For example, the Commission can include case studies and stories of lived experiences from consumers, carers, families, and support people in its reporting so that stories provided directly by consumers and carers are central to reporting. These stories may be gathered through consumer and carer surveys. There is also an opportunity to partner with researchers and community organisations to access qualitative data.

3. The Commission could analyse and compare data at national, jurisdictional and sub-jurisdictional levels, where possible

The Commission could provide an aggregated national picture of mental health and suicide in Australia, but could also provide information on what is occurring at the jurisdictional and sub-jurisdictional levels. This approach was strongly supported by those consulted in the national consultation, including by people living in places with unique and diverse service contexts (such as the Northern Territory).

The Commission could add value through this jurisdictional and sub-jurisdictional analysis by providing comparisons, highlighting areas of best practice, and identifying opportunities to drive improvements.

4. The Commission could use its monitoring and reporting role to highlight data gaps, and could inform data development and data linkage efforts in the sector

Several data challenges significantly limit the potential for monitoring and reporting in Australia. These include:

- a lack of standardisation in how data not in National Minimum Data Sets (NMDSs) are gathered across jurisdictions and different service providers (e.g. community setting)
- no linkage between data sets held by different sectors and jurisdictions
- gaps in data collections, including for particular topics, and service types (such as private psychiatry) and population groups (including rural and remote stakeholders)
- a lack of measures designed by people with lived experiences.

The Commission is well-positioned to champion or, where resourcing is available, directly commission data development efforts in the sector by working with data custodians. The Commission could work with others in the sector to:

- encourage further efforts to improve data linkage between different sectors and jurisdictions (e.g. data sets in housing, ageing, disability, labour force and workforce, private health insurance, and mental health service provision)
- encourage data gaps to be addressed, including qualitative data, consumer and carer data and outcome data
- encourage new types of data and methods of analysis, including longitudinal data and cross-sectional data.

3.3.3 Stakeholder collaboration

It is essential for the Commission to actively work with others in the sector to implement the proposed Framework and to achieve successful monitoring and reporting. This includes external and internal stakeholders, such as the Commissioners. The Commission could pursue stakeholder collaboration to support the following three Framework implementation functions:

1. **Data access**: The Commission is not a primary data collector, and therefore would need to collaborate closely with others who collect data and are data custodians.
2. **Data development and linkage**: The Commission does not have capacity to lead data development and linkage efforts on its own, but could collaborate with others and commission others to do this.
3. **Advisory input for monitoring and reporting:** The Commission could engage with others in the sector to receive advice on priorities and processes for monitoring and reporting priorities. The Commission could ensure that the voices of consumers and carers are strongly represented in this advisory input.

The Commission currently engages in regular public consultation with the sector and broader community to inform monitoring and reporting activities and the Commission's other functions. The Commission could draw from this ongoing consultation to define its annual monitoring and reporting focus areas.

The Commission's consultation may include the use of online consultation tools (e.g. Citizenspace) and face-to-face consultations with groups such as the Mental Health Information Strategy Standing Committee (MHISSC)[51] and the National Mental Health Consumer and Carers Forum.

[51] MHISSC brings together jurisdictional mental health data representatives and key stakeholders including consumers, carers, clinicians, peak bodies and key organisations. The Committee provides a national collaborative forum for the development and implementation of national initiatives in mental health information, and provides expert technical advice and recommendations for the information requirements of the National Mental Health Strategy.

Consultation may also include calls for public submissions. The extent and mode of regular consultation would be guided by the Commission's resourcing and capacity limitations.

Figure 5 describes the collaborative relationships that the Commission could seek to develop and maintain to enable successful implementation of the Framework.

Figure 5: Collaborations to enable Framework implementation

Stakeholder group	Data access collaboration	Data development and linkage collaboration	Advisory input for monitoring and reporting
Consumer and carer groups	✓		✓
State and Territory Health and Social Services Departments	✓	✓	✓
State Mental Health Commissions	✓	✓	✓
Key Commonwealth Departments and agencies *including the AIHW, ABS, and NDIA*	✓	✓	✓
Inter-jurisdictional committees, *including MHISSC and the Mental Health Principal Committee (MHPC)*	✓	✓	✓
Not for profit organisations	✓	✓	
Researchers	✓	✓	

4 Conclusion

Australia's current mental health and suicide prevention landscape is complex and dynamically changing due to the influence of several major reforms. Within this context, there is a continued need for impactful and accessible monitoring and reporting at the national, jurisdictional and sub-jurisdictional level.

The development of the proposed Framework has highlighted strengths and gaps in the current mental health and suicide prevention monitoring and reporting landscape. Due to its role as a national and independent catalyst for change, the Commission has a unique opportunity to contribute to the national monitoring and reporting landscape to enable positive change for consumers, carers, and the broader sector.

The Commission could begin implementation of the Framework over 2018-2022 based on the input from national consultations with stakeholders. The Commission could also review and reprioritise its approach to monitoring and reporting on a regular basis to ensure it uses its finite resourcing to achieve maximum value for the sector.

Many other organisations and individuals play critical roles in the Australian mental health and suicide prevention monitoring and reporting landscape. The impact of the Commission's monitoring and reporting will be dependent on strong, collaborative relationships with these other stakeholders in the mental health and other external sectors, including those with lived experience of mental ill health. This collaboration will be critical to enable the Commission to catalyse positive change in the mental health and wellbeing of all Australians.

Appendix A People and groups consulted with in the development of the Framework

Stage 1 consultations

The following people and groups were consulted with in Stage 1 of the project, from July to September 2017.

Stakeholder group	People consulted with
National Mental Health Commissioners	• Prof Allan Fels AO • Jackie Crowe • Prof Pat Dudgeon • Prof Ian Hickie AM • Rob Knowles AO • Lucinda Brogden • Nicole Gibson • Dr Peggy Brown
Project Advisory Committee	• Dr Peggy Brown, CEO, National Mental Health Commission (Chair) • Noel Muller, consumer representative • Jackie Crowe, National Mental Health Commissioner • Prof Ian Hickie AM, National Mental Health Commissioner • Gary Hanson, Head of Mental Health and Palliative Care Unit, Australian Institute of Health and Welfare • Lyn English, consumer representative • Richard Weston, Healing Foundation • Lisa Hillan, academic representative (proxy for Richard Weston, Healing Foundation)
State Mental Health Commissions	• John Feneley, NSW Mental Health Commissioner • Ivan Frkovic, Queensland Mental Health Commissioner • Tim Marney, Western Australia Mental Health Commissioner • Chris Burns, South Australia Mental Health Commissioner • Amelia Traino, Executive Director South Australia Mental Health Commission
Australian College of Mental Health Nurses	
Australian Institute of Health and Welfare	
Australian Commission on Safety and Quality in Health Care	

Australian Bureau of Statistics
Community Mental Health Australia
Productivity Commission
Department of Health
Department of Social Services
Department of Veteran Affairs
Mental Health Australia

Stage 2 consultations

A range of stakeholders participated in the national workshops and online survey, including carers, consumers, and their families, health professionals, service providers, representative bodies, PHNs, academic institutions, and representatives from Commonwealth and State and Territory governments.

The following people and groups were consulted with in Stage 2 of the project through additional consultations, between October and December 2017.

Stakeholder group
Australian Commission on Safety and Quality in Health Care
Australian Defence Force
Australian Institute of Health and Welfare
Community Mental Health
Mental Health Australia
Mental Health Information Strategy Standing Committee
Mental Health Principal Committee
Mind Australia
National Mental Health Consumer and Carer Forum
National Aboriginal and Torres Strait Islander Leadership in Mental Health
National LGBTI Health Alliance

Appendix B Stage 2 Consultation Report, November 2017

About this report

The National Mental Health Commission (the Commission) engaged Nous Group (Nous) to develop a National Mental Health and Suicide Prevention Monitoring and Reporting Framework (the Framework) to guide its monitoring and reporting on mental health and suicide prevention.

In October and November 2017, the Commission and Nous consulted widely with stakeholders on the potential features of the Framework, which were outlined in the national consultation material document.

About the Framework

The Framework will guide the Commission's national independent monitoring and reporting on mental health and suicide prevention over the next five years (2018-22). The Framework will act as a roadmap for the Commission's activities, by capturing the domains[52] that the Commission will monitor and report on at various stages over this timeframe.

The purpose of the Framework is to provide national independent monitoring and reporting of mental health and suicide prevention. The Commission is an independent body and it will use the Framework to add value, increase accountability and act as a catalyst for change. The Commission will use the Framework to provide a national and inter/cross-sectoral picture of the system, to outline what is needed to improve the mental health of people in Australia.

The Framework will also identify data sources, opportunities for analysis, data development, and reporting formats and frequency. The Commission's objectives are to enable value-add reporting that builds on (rather than duplicates) reporting activity elsewhere in the mental health sector.

About the consultation and who we heard from

From July to September 2017, Nous and the Commission conducted preliminary consultations with a selection of key stakeholders, and conducted an environmental scan of recent Australian national mental health and suicide prevention policies. This exercise confirmed there are a number of gaps and limitations from current reporting. We used these insights to develop the potential features of the Framework, as outlined in the national consultation material document.

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[52] Domains are areas of focus, or topics, within mental health and suicide prevention.

The Commission and Nous then consulted with mental health and suicide prevention stakeholders across Australia on the national consultation material document in October and November 2017. It was important for us to speak with stakeholders to learn from their diverse and collective expertise, and ensure that we created a Framework that is fit for purpose and will support the Commission to act as a catalyst for change in mental health and suicide prevention.

A range of stakeholders participated in the consultations, including carers, consumers, and their families, health professionals, service providers, representative bodies, PHNs, academic institutions, and representatives from Commonwealth and State and Territory governments. Invitations were sent from the Commission's mailing list and the national consultation process was promoted through the Commission's website and newsletter.

The consultation process comprised:

- workshops in each State and Territory capital city which were open to all people
- an online survey accessible to all people
- additional consultations with additional key stakeholder groups:
  - Consumers and carers through the national workshops and a targeted consultation through the NMHCCF – 23 attendees
  - MHISSC – 27 attendees
  - Australian Institute of Health and Welfare (AIHW) – Head of Mental Health and Palliative Care Unit
  - Mental Health Principal Committee (MHPC) – seven attendees
  - National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) – three attendees
  - National Lesbian Gay Bisexual Transgender and Intersex (LGBTI) Health Alliance – five attendees
  - Australian Commission on Safety and Quality in Health Care (ACSQHC) – three attendees
  - Community Mental Health Australia – three attendees
  - Mind Australia – one attendee
  - Mental Health Australia – two attendees, and
  - Australian Defence Force – three attendees.

Overall, we consulted with over 195 people at 13 workshops. We also received 303 survey responses.[53]

This consultation report outlines the key themes from these stakeholder consultations. Participant feedback from the consultations is distilled in the "What you told us" section of this document. Nous and the Commission used this feedback to inform the development of the final Framework and its accompanying Implementation Plan.

[53] We received 84 completed survey responses, where respondents answered all survey questions. We received an additional 219 partially completed survey responses where respondents may have skipped questions, or not reached the end of the survey. We included the data from partially completed surveys in our survey analysis.

What you told us

This section of the document summarises the key themes we have heard through the national consultations. The section firstly discusses overarching consultation themes, before summarising feedback on specific components of the Framework.

Overarching consultation themes

Throughout the consultations we heard a number of broad themes that applied across all components of the Framework. These overarching themes are discussed below.

Your key themes	What you told us
Consumers, carers, families and support people must be central to the Framework	• The principle of 'person-centeredness' should be apparent throughout the whole Framework • It is essential that lived experiences inform all aspects of the Framework as well as the Commission's ongoing monitoring and reporting
A number of important issues should be emphasised in the Framework	• Stigma and discrimination needs to be more clearly reflected in the Framework, and should be considered across the multiple levels of community stigma, service provider stigma and self-stigma. • The Framework requires a clearer view of suicide prevention separate from mental health, rather than combining suicide and mental ill health. • The spectrum of mental ill health needs to be reflected in the Framework. In particular, severe and persistent mental illness requires a dedicated focus. • The Commission's Contributing Lives Framework needs to have a stronger presence in the Framework.
The Framework needs to be ambitious and nuanced, but also feasible	• The Framework should be ambitious and not just aim to monitor and report on what is available and easy. However, this ambition needs to be balanced with feasibility over the Framework's different timeframes and the Commission's capacity. • It is important to produce monitoring and reporting with a whole-of-system view that considers how elements are connected rather than considering them in isolation • The cultural and service environments in different states and territories vary significantly and the Framework should enable these differences to be monitored and reported. • The Framework should attempt to monitor and report on the impact of a broad spectrum of services and programs that influence the mental health of Australians, including different settings (e.g. government, non-government and private) and different sectors (e.g. the health sector, social services, and others).

We should reconsider the presentation of the Framework	• The Framework categories and domains may need to be reshaped or explained further to aid clarity and address concerns about overlapping domains. • The Framework has a similar logic and presentation to the National Health Performance Framework, but uses different language that does not fully align. This risks confusion about the relationship between the documents. • Some participants thought that we should reconsider how key reforms are ordered and captured in the Framework, and clarify their emphasis and prioritisation. Some participants raised the question of whether to include state- and territory-based plans in the Framework. • Some participants questioned the role of the Commission to monitor PHNs.

Domains – social, system and population

The following section details participants' key themes on the Framework's potential social, system and population domains. We asked participants which domains should be included or removed in the Framework, and which ones should be prioritised. The summary below highlights the themes that were most generally supported across the consultation process.

Participants commented on the overlap across domains suggesting the categorisation of domains requires re-considering and further exploration.

Social domains

Your key theme	What you told us
A few additional domains, particularly from social services, could be included in the Framework	• There should be a strong emphasis on prevention and the causal and risk factors for mental ill health and suicide. • There was a strong theme across workshops that it would be valuable for the Commission to look across additional social domains, particularly in social services (domestic and family violence; trauma; child abuse and neglect). • The justice system domain should be further nuanced, including a specific focus on sexual assault and the youth justice system. • Gambling and physical health were also raised as additional social domains that the Commission should consider, due to their interrelationship with mental health and suicide prevention.
The Commission should prioritise monitoring and reporting of some social domains	• Stakeholders emphasised a few social domains for particular prioritisation. These include community connections, housing and homelessness, drugs and alcohol, the justice system, and disability. Survey participants in particular prioritised homelessness and community connections. • Stakeholders' prioritisation was often grounded by references to current reform policies (for example the introduction of the NDIS in many jurisdictions).

System domains

Your key theme	What you told us

The Commission's monitoring and reporting of the system could include additional domains	• Stakeholders were generally satisfied with the domains that the Commission has proposed to include in the draft Framework. There were suggestions for additional domains for the Commission to report on:
	  • The mental health workforce, particularly the carer workforce.
	  • The funding and sustainability of the system.
	  • The consistency and coordination of Commonwealth and State and Territory legislation.
	  • The safe environment and design of mental health service delivery locations.

The Commission should focus on some system domains in particular	• The domain of accessibility and equity, including rural/remote service gaps should be prioritised. This was often referenced as an important aspect of monitoring the implementation of PHNs. • The consumer and carer participation domain was seen as particularly important, but as also requiring some further nuance. In particular, there is an opportunity to look beyond consumer and carer participation to consumer and carer leadership. • Other strong themes from participants were the prioritisation of the following domains: continuity and integration, sustainability and capability, and safety, quality and responsiveness. Survey respondents prioritised continuity, integration, accessibility and equity.
The Commission should monitor and report across all elements of the mental health system, as well as intersectional points with other systems	• The Framework should attempt to monitor and report on the impact of a broad spectrum of services and programs within the mental health system, including private psychiatry and the NDIS. Stakeholders also observed that the system indicators have too strong a clinical focus, and should consider factors such as community first responders. • The mental health system overlaps significantly with other human services systems, and the impact and accessibility of these services is crucial should be looked at.

Population domains

Your key theme	What you told us
The Commission could report on a variety of specific indicators to understand issues within and across the population	• Participants were broadly supportive of the population themes identified by the Commission, but they were seen to be at a high level and would benefit from more specific areas of focus. They proposed it would be beneficial for the Commission to report on some specific indicators such as a 'community happiness' indicator to measure positive wellbeing in the community. This was a strong theme at the Hobart workshop. Another suggestion included a measure of unmet need in the population, mental health literacy in the population, and more accurate measurement of suicide / suicidality, and intentional self-harm. • The Sydney and Adelaide workshops particularly emphasised the important of measuring early years intervention and its impact on future life outcomes. Participants also raised the importance of defining the age bracket for this category.
The Commission should prioritise a subset of population domains	• Quality of life and outcome measurements are a high priority. These indicators should be broad and include a consideration of prevention, rather than a focus on the acute end of mental ill health and suicide. There is also a need for improved reporting on suicide, suicide attempts, and intentional self-harm, and better capturing of this data by primary data collectors.
The Commission should also monitor and report different types of mental ill health within the population	• Monitoring and reporting should identify high need, low prevalence disorders and disability as well as high prevalence disorders and population level measures. • Mental ill health and suicide should be separated because conflating them lessens the impact of each group and suicide may occur because of life stressors and not as a result of mental ill health. There would also be benefit in monitoring and reporting the prevalence and outcomes relating to specific conditions, for example bipolar disorder.

Priority groups

We asked participants which population groups should be Included or removed in the Framework, and which ones should be prioritised. Participants' key themes of feedback on the Framework's priority groups are outlined below.

<table>
<tr><th>Your key theme</th><th>What you told us</th></tr>
<tr><td>We should reconsider the language and framing of the priority groups</td><td>There needs to be more definition around the purpose of the priority groups, and some additional priority groups.
There is an opportunity to reconsider the language and framing of priority groups to ensure it is person-centred and emphasises that every person is important. This was a theme across most workshops.
The analysis of priority groups should account consumers who identify with multiple population groups</td></tr>
<tr><td>There are further refinements we can make to the existing proposed priority groups</td><td>The Framework should give further emphasis to the following priority groups:
Children and young people. This population group was prioritised by survey respondents.
Lesbian, gay, bisexual, transgender, queer/questioning, intersex (LBTQI) people.
Rural and remote populations. This was a particularly strong theme at the Hobart and Darwin workshops.
There is a need to rephrase or separate the priority group of 'dual disability and dual diagnosis'.
People with co-morbid use of drugs and alcohol.
People with lived experience of mental ill health and an intellectual or other disability
The PHN priority groups should include Aboriginal and Torres Strait Islander people, Children and Young people, and Drugs and Alcohol.</td></tr>
<tr><td>Participants suggested adding several additional priority groups</td><td>Participants suggested a range of priority groups to consider adding to the Framework:
Asylum seekers
Children in out of home care
Children of parents with mental ill health
Men (from the perspective of suicide prevention)
Homelessness
People who use drugs</td></tr>
</table>

- Workforces that experience trauma, for example police, ambulance staff and other emergency services
- Fly-in fly-out workers. This was a particularly strong theme at the Perth and Darwin workshops.
- Carers
- Perinatal health
- People with low prevalence disorders, such as severe and complex mental illness and eating disorders
- People affected by domestic and family violence
- Prisoner populations.

Participants also recognised the Commission's reporting is constrained by resources, and as a result the Commission would be unable to meaningfully report on all additional priority groups suggested for inclusion in the Framework.

Opportunities to add value through analysis

We asked participants what the key opportunities are for the Commission to add value through data analysis. As part of this feedback process, we specifically tested four opportunities for analysis which we had previously identified. Participants' key themes of feedback on opportunities to add value through analysis are outlined below.

Your key theme	What you told us
We received consistent feedback on our identified opportunities for analysis, with strong support for data linkage	• Data linkage was a strongly supported opportunity by all consultation participants. However, it was recognised that there are challenges to link data between government, non-government and private services. • Obtaining and linking data from private services poses additional challenges. There are concerns about a lack of data from the private sector, and participants noted there are big gaps in data on private psychiatry. Existing private sector data is rarely linked to public sector data. • The Commission has a significant opportunity to encourage for data gaps to be addressed. The Canberra workshop highlighted that this is a need for small population groups. • Many participants also supported the idea of jurisdictional and sub-jurisdictional analysis. This was a particularly strong theme at the Darwin workshop, given the Northern Territory's diversity and unique service context. • Opportunities for use of social media, internet and other digital data were less favoured across workshops, except for the Sydney workshop. I.e. more contemporary analysis ideas were not considered a priority for the Commission. Participants generally agreed that the Commission should incrementally explore this opportunity through pilot cases.
There are further ways for the Commission to add value	• The Commission can add value by highlighting examples of best practice and reporting the impact of state and territory performance. • Qualitative data is valuable and can complement quantitative data, and that the Commission should meaningfully collect and report on qualitative data.
The Commission has several significant challenges to consider	• A lack of data standardisation between state and territories as well as different service providers is a key challenge for monitoring and reporting. • Access to data is also a significant challenge, as it is often dependent on relationships and the goodwill of data custodians. • Some priority groups are not sufficiently covered in routine data collections. This was highlighted at the Hobart and Darwin workshops.

There are opportunities to engage consumers and carers in data gathering and analysis	• Information and stories provided directly by consumers and carers should be central to the framework. These may be gathered through consumer and carer surveys and there is opportunity to partner with researchers and community organisations to access qualitative data. • There is a gap and opportunity in the sector to use measures designed by people with lived experiences, for example the Australian Government's Your Experience of Service Survey (the YES Survey).

Flexible reporting

We asked participants what mental health and suicide prevention information sources they most use, and if there are any reporting formats that the Commission should consider. Participants' key feedback themes on flexible reporting are outlined below.

Your key theme	What you told us
Reporting should be interesting and engaging for everyone	• Most participants agreed with the Commission's supposition that it is essential that there is mixed media, formats of levels of detail that are tailored to different audiences. • To supplement traditional formats, the Commission should also consider online reporting formats to provide succinct, engaging content (for example, social media communications, annual report microsites and videos). • Many participants, particularly from the Consumer and Carers Forum, indicated that visuals and plain language is very important for reports. Participants also raised innovative approaches for qualitative reporting, including story-telling. • Traditional formats such as annual reports, topical reports and raw data tables remain relevant and valuable to many audiences.
Reports should be accessible and allow the user to quickly understand a range of issues	• The Commission should synthesise key messages and distribute these to a broad range of audiences. • Accessibility needs (including, for example, language and literacy barriers) need to be considered at the design phase of the report. Participants in Hobart, Canberra and Darwin noted the need to accommodate lower literacy levels and plain English. Participants at the Consumer and Carers forum and the Perth and Darwin workshops noted that a lack of internet connection for many of the Commission's audience should be considered.
Reports should allow audiences with a deep interest in the evidence base to 'drill down' into areas of focus	• It is important to enable 'drilling down' so people can look up information relevant to them and where they live.

Appendix C National Consultation Materials

Introduction

The National Mental Health Commission (the Commission) engaged Nous Group (Nous) to develop a framework to guide its monitoring and reporting on mental health and suicide prevention. This work has been informed by a review of mental health and suicide prevention policies, previous and existing monitoring and reporting, as well as wide stakeholder consultation. The Commission is currently seeking input through a national consultation to inform the development of the final Monitoring and Reporting Framework on Mental Health and Suicide Prevention (the Framework), which will be available in early 2018.

The Framework will guide the Commission's national independent monitoring and reporting on mental health and suicide prevention over the next five years (2018-22). The Framework will act as a roadmap for the Commission's activities, by capturing the domains[54] that the Commission will monitor and report on at various stages over this timeframe. It will also identify data sources, opportunities for analysis, data development, and reporting formats and frequency. The Framework will include health and social outcomes, system performance and population mental health and wellbeing for consumers, carers, families and support people. Through its monitoring and reporting, the Commission will track the progress of reform commitments, investigate whether they are making a difference and use this information to inform future policy, practice and research priorities.

Purpose of this document

This consultation paper provides information on the potential features of the Framework as background to allow participants in our national consultation to provide feedback via:

- an online consultation survey, and
- national consultation workshops.

The Commission welcomes feedback on the potential features of the Framework, and is particularly interested in how its collection, monitoring, and reporting of information can be more innovative, systematic and consumer-focused, to support the Commission to be a catalyst for change and system reform. The Commission's objectives are to enable value-add reporting that builds on (rather than duplicates) reporting activity elsewhere in the mental health sector.

[54] Domains are areas of focus, or topics, within mental health and suicide.

The national consultation period is 16 October to 17 November 2017.

If you have any questions about the potential features of the Framework or the consultation, please contact Nous on nmhc.mrf@nousgroup.com.au

For information about the Commission, please visit www.mentalhealthcommission.gov.au

Background to the development of the Framework

National monitoring and reporting on mental health and suicide prevention is a core role of the Commission. Since its establishment in 2012, the Commission has undertaken this role in various ways, with different formats, structures and areas of focus. This new framework will provide a consistent foundation to structure and guide its national monitoring and reporting on mental health and suicide prevention over the next five years (2018-22) and into the future.

Many organisations contribute to the mental health and suicide prevention monitoring and reporting landscape in Australia. However, an environmental scan of recent Australian national mental health and suicide prevention policies confirms there are gaps and limitations in current monitoring and reporting. There is an opportunity for the Commission to address these gaps and limitations through the Framework, including coverage of policy and reform directions, monitoring and reporting domains, and population groups. There is also potential to improve data sources, analysis, and reporting formats and frequency.

Figure 1 summarises the current areas of focus in the Australian mental health and suicide prevention policy and reform agenda.

Figure 1: Mental health and suicide prevention policy and reform agenda focus areas

Characteristics of care

Person centred	The right care at the right time, delivered in diverse settings, that respond to the needs of the consumer.
Integrated and coordinated	Integrated and coordinated care across health and social domains (including education and disability care) and in all settings (i.e. stepped care).
Accessible	Care that is easy for consumers to request and receive.
Safe and quality	Care that is safe for the consumer and of a high quality.
Local interventions	Local and regional planning and service delivery that reflects the context of the community.

Specific population groups

Aboriginal and Torres Strait Islander	Approaches to care that reflect the unique cultural and spiritual needs of Aboriginal and Torres Strait Islander people and communities.
LGBTQI	Approaches to care that reflect the specific needs of LGBTQI people and communities.

Broader initiatives

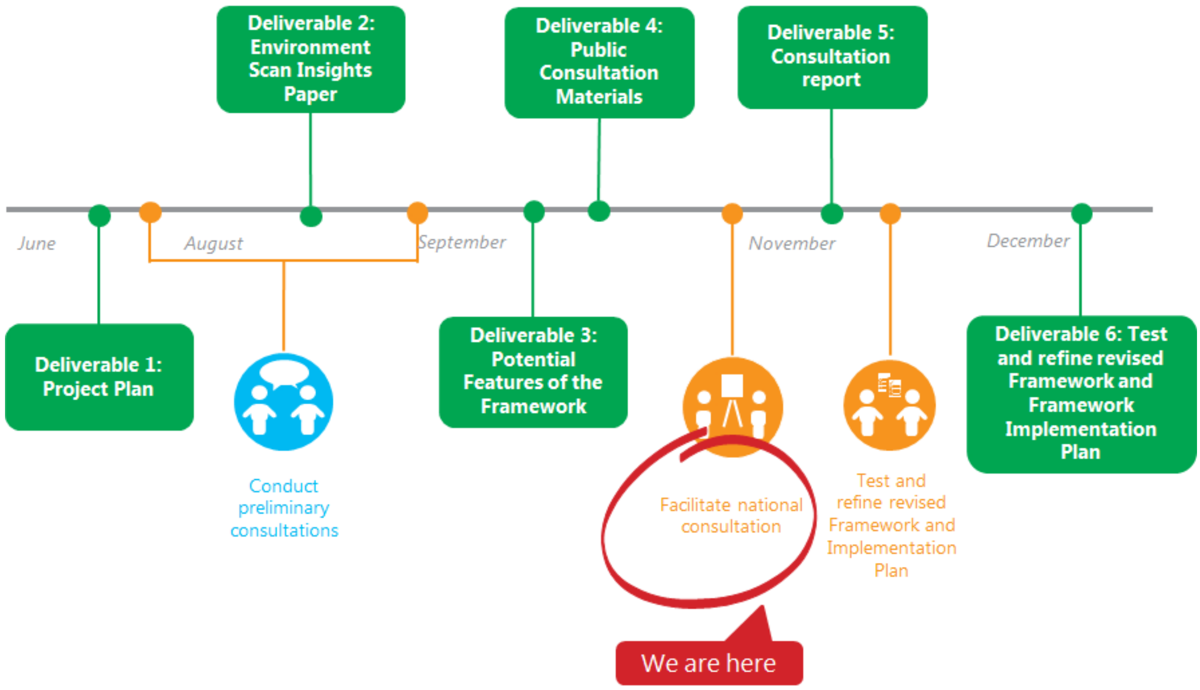
Suicide prevention	Investment in services and approaches that support the prevention of suicide.
Stigma reduction	Reduction of the stigma that can be associated with mental health issues.
Prevalence of mental health	The mapping of prevalence of mental health.
Prevention and early intervention	Services and approaches that facilitate prevention and early intervention.

While the Framework will provide a comprehensive overview of the Commission's approach to monitoring and reporting on mental health and suicide prevention, the Commission's capacity to deliver on the entire scope is dependent upon the level of resourcing available to it and competing demands within its work plan. At a minimum, the Commission will report against the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan). The Commission will also monitor and report on the reform priorities arising from the Contributing Lives, Thriving Communities Review of Mental Health Programmes (Contributing Life), the National Disability Insurance Scheme (NDIS), and Primary Health Networks (PHNs) to the extent that the Commission is able to within allocated resources. The Commission's capacity to conduct additional monitoring and reporting beyond this will be determined by the resources available.

The frequency with which the Commission will report on the different domains of the Framework will be confirmed in an Implementation Plan, which will be completed once the Framework is finalised. The Implementation Plan is expected to provide a five-year (2018 - 2022) overview of the timing and frequency of reporting for each domain. The Commission will review this plan annually to maximise the value of its monitoring and reporting.

Figure 2 outlines the process underway for developing the Framework.

Figure 2: Work undertaken to date



Purpose of the Framework

The purpose of the Framework is to provide national independent monitoring and reporting of mental health and suicide prevention. Table 1 expands on what the Framework aims to achieve.

Table 1: What the Framework aims to achieve

Aims	Description
Adding value	The Commission will use the Framework to tell a story. The Framework seeks not to duplicate existing monitoring and reporting in Australia – but to add value to this context by drawing together and analysing different data sources and seeking to highlight and fill gaps in current reporting.
Independent	The Commission is an independent body and will use the Framework to support its monitoring and reporting on mental health and suicide prevention in order to continue to provide independent advice to governments and the community.
Catalyst for change	The Commission will use the Framework to monitor and report for the purpose of instigating positive change for mental health and suicide prevention.
Increase accountability	The Commission will use the Framework to increase accountability of the mental health system through fair, timely and transparent reporting.
National coordination role	The Commission will use the Framework to provide a national picture of the system by reporting on activities undertaken by Commonwealth, State and Territory Governments, across the health and social services sectors, and across public, non-government and private sectors.
Inter/cross-sectoral	The Commission will use the Framework to monitor and report on all aspects of a contributing life for people who experience mental illness and suicidality. This means that Commission will not only report on the health sector, but on broader factors such as social inclusion, education, the justice system, and housing stability.
For people in Australia	The Commission will use the Framework to reflect an agreed and common understanding of the aspects of mental health and suicide prevention monitoring and reporting that are needed to improve the mental health of people in Australia.

Potential features of the Framework

Given the complexities of mental health and suicide prevention monitoring and reporting, an overview of potential features of the Framework is provided at Figure 3. These features include:

- The **purpose** describes what the Commission aims to achieve through the Framework.
- The **reporting audiences** describe key audiences for the Commission's monitoring and reporting.
- The **guiding principles** describe the manner in which the Commission proposes to monitor and report in order to best provide value to its reporting audiences.
- The Framework includes three **domain categories**, including:
  - *Social* – the broader social factors that impact mental health outcomes of people in Australia
  - *System* – the performance of health and social services that impact mental health outcomes of people in Australia, including system inputs and service-level processes and outputs
  - *Population* – the impacts and outcomes of social contexts and system performance; these reflect the key mental health and wellbeing outcomes of people in Australia at both the individual and population level.

The proposed domains align to four reform priorities:

1. the Fifth Plan
2. the Contributing Lives Framework
3. the NDIS
4. the establishment of PHNs.

- In addition to the general population, the Framework includes **priority groups** that will be specifically monitored and reported on. Due to levels of need, difficulties with service access or other concerns, these priority groups require a specific focus to supplement broader monitoring and reporting on the mental health status of on the general population.
- Identified in the Framework are **priority reform areas** proposed for monitoring and reporting over the next five years (2018 – 2022). Depending on policy directions, reform progress and changing areas of focus, additional domains may become priority areas for monitoring and reporting at a later stage.
- Finally, the **monitoring and reporting outcome** describes what the Commission wishes to achieve through its monitoring and reporting.

Figure 3: Overview of potential components of the Framework

Potential features of the Mental Health and Suicide Prevention Monitoring and Reporting Framework

Australian Government
National Mental Health Commission

Purpose

To provide national independent monitoring and reporting on mental health and suicide prevention.

Report audiences

Consumers; carers, families and support people; service providers and the mental health workforce; and policy and decision makers.

Guiding principles

Utilise data to tell a story; person-centred; outcomes focused; and inter-sectoral.

PRIORITY REFORM AREAS	DOMAINS: 1. SOCIAL	DOMAINS: 2. SYSTEM	DOMAINS: 3. POPULATION	PRIORITY GROUPS
Fifth Plan	• **Community connections** • **Employment** • **Housing and homelessness**	• **Accessibility and equity** • **Consumer and carer participation** • **Continuity and integration of care*** • **Safety, quality and responsiveness**	• **Prevalence of mental ill health, suicide and suicide attempts*** • **Mental health outcomes*** • **Broader quality of life outcomes**	• **Aboriginal and Torres Strait Islander people** • **Children and young people** • **People with a dual disability and dual diagnosis***
Contributing Lives	• **Community connections** • **Education*** • **Employment** • **Housing and homelessness** • Disability* • Drugs, alcohol and tobacco* • Economic* • Justice system* • Technology and e-mental health*	• **Accessibility and equity** • **Consumer and carer participation** • **Continuity and integration of care*** • **Safety, quality and responsiveness*** • Capability* • Sustainability*	• **Prevalence of mental ill health, suicide and suicide attempts*** • **Mental health outcomes*** • **Broader quality of life outcomes**	• **Aboriginal and Torres Strait Islander people** • **Culturally and linguistically diverse communities*** • **Children and young people** • **Older people*** • Defence personnel and veterans* • Lesbian, gay, bisexual, transgender queer or questioning, and intersex people* • Refugees* • Rural and remote populations*
NDIS	• **Disability**	• **Accessibility and equity** • **Continuity and integration of care*** • Efficiency*	• **Mental health outcomes*** • **Broader quality of life outcomes**	• **People with dual disability and dual diagnosis*** • Aboriginal and Torres Strait Islander people • Children and young people
PHN		• **Accessibility and equity** • **Continuity and integration of care*** • **Consumer and carer participation** • **Safety, quality and responsiveness** • Capability* • Efficiency* • Sustainability*	• **Mental health outcomes*** • **Broader quality of life outcomes**	• **People with dual disability and dual diagnosis***

Key: Bold domains are priority reform domains for 2018-2022 * indicates areas for future development, likely for 2023 onwards

Monitoring and reporting outcome: Positive change in mental health and wellbeing for all Australians, enabling people to lead a contributing life and to be part of a thriving community.

This visual has been produced to aid the national consultation process on the Framework. The Framework will be developed following the national consultation process.

Social domains

Social domains include conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.[55]

Table 2 describes social domains that could be monitored and reported on in the Commission's Framework.

Table 2: Social domains

Social
Focus domains (over the next five years)
1. Community connections: Healthy relationships with family, friends, community and culture
Healthy relationships with family, friends, community and culture create a sense of belonging. Social isolation is strongly linked to mental health issues and suicidality.
2. Education: Mentally healthy places to learn
Access to education provides further opportunity for more productive workforce participation. A known correlation exists between education and mental health such that lower levels of education indicate higher prevalence rates of mental ill health, while higher levels of education (along with mentally healthy places to learn) promote positive mental wellbeing.
3. Employment: Mentally healthy workplaces
Employment status and mentally healthy workplaces impact on a person's ability to financially support themselves and their families. Employment is often a significant component of a person's identity. Unemployment decreases social connectedness and financial stability, increasing the risk of mental ill health and suicidality.
4. Housing and homelessness: Stable and safe places to live
Housing status and a person's living environment can impact on safety, security, employment opportunities and overall wellbeing. Housing safety and stability is particularly important for people with mental ill health. Homelessness increases a person's vulnerability and diminishes their personal security.
5. Disability: A society that supports people with a disability to live contributing lives
Disability status and the type of disability can negatively impact on a person's ability to actively engage and participate in society, as well as other aspects of health including their mental health. A society that supports people to live contributing lives can improve mental health outcomes.

[55] World Health Organization, Definition of Social Determinants of Health. Accessed online 23 August 2017 <http://www.who.int/social_determinants/sdh_definition/en/>

Additional domains
6. Drugs, alcohol and tobacco: Minimising the use of harmful substances
Excessive consumption of alcohol, use of tobacco, illicit drugs, and/or misuse of pharmaceutical drugs can impact negatively on a person's health. Substance abuse can further result in increased risk taking behaviours, along with financial, health and interpersonal stressors that can negatively impact on a person's ability to live a contributing life.
7. Economic: Having the means to live a contributing life
Economic security is fundamental to an individual's ability to lead a contributing life. The effects of economic uncertainty can be seen at the population level, where access to health and social services may be impacted by broader macroeconomic trends e.g. austerity vs. economic stimulus. It may also be viewed from the micro perspective, where a person living with mental ill health may be unable to participate fully in employment, both limiting their economic engagement, and producing ongoing barriers to recovery and a stable occupation.
8. Justice system: A justice system that supports positive mental health and wellbeing
Criminal activity and exposure to the criminal justice system, particularly through detention, is linked to the development and/or exacerbation of mental ill health. Similarly, in some cases mental ill health can increase risk of criminal activity. Victims of crime are also more at risk of mental ill health and suicidality. It is important that the justice system supports positive mental health and wellbeing.
9. Technology and e-mental health: Connecting and supporting online
Technology and social media have changed the way people communicate and connect. The extent to which this impacts on mental health and suicide is yet to be fully determined, but there is an increase in research in this space. The digital environment has also acted as a disruptor for mental health service delivery.

System domains

For the purposes of the Framework, the term 'system' describes the activity of all organisations and resources focused on providing care to improve the mental health and wellbeing for people in Australia.[56] This also includes relevant organisations and resources in the broader Australian health and social services systems, given the highly interrelated nature of mental health with broader health and social determinants.

System performance spans a range of different support types. Importantly, it will examine activities in all settings (including acute care, primary care and community-based care), and activities delivered across service providers (public supports, private supports and non-government sector supports). The Framework will support monitoring and reporting of the following:

1. **Promotion, prevention and early intervention** – including educational awareness programs and early intervention supports.
2. **Primary health care** – including general practice and community health.
3. **Community based supports** – including community based care provided by state and territory managed services and the non-government sector.
4. **Residential mental health services** – includes bed based supports.
5. **Hospital supports** – including public and private sector acute and non-acute bed based services.
6. **Private health supports** – including office-based supports such as private psychiatry and psychology.

The potential features of the Framework include eight system domains to provide a comprehensive picture of how the Australian system performs in response to mental health and suicide. Each of these domains is described in Table 3.

Table 3: System domains

System
Focus domains (over the next five years)
1. Accessibility and equity: Timely access to care for all
Accessibility and equity refers to the system's ability to provide all consumers in Australia with the supports they need, when they are needed, irrespective of factors such as income, geography and cultural background. This is important to ensure timely and proactive care for consumers. Under the Fifth Plan, the Commission will report on population access to mental health care. This domain includes:

[56] Adapted from the following definition: World Health Organization. Assessment Instrument For Mental Health Systems, p. 10. 2005.

- the availability of mental health supports across different geographical regions and demographics
- waiting times for consumers to access mental health supports
- the proportion of consumers who have difficulty accessing mental health supports
- changes to the availability of supports to people with psychosocial disabilities due to the implementation of the NDIS
- the extent to which any difficulty accessing services can be attributed to a measure such a geographical location, ethnicity, gender, religion etc.

2. Consumer and carer participation: A system shaped by people with lived experiences

Consumer and carer participation refers to the representation of consumers and carers at all levels of the system, including policy development, service planning, delivery, evaluation and research. This domain supports a person-centred system that is shaped by people with lived experiences of mental ill health and suicidality. Under the Fifth Plan, the Commission will report on the proportion of total mental health workforce accounted for by the mental health peer workforce. This domain includes:

- consumer and carer reported measures of involvement in care planning and decisions
- the representation of consumers and carers in the senior governance of service provider organisations
- the engagement of consumers and carers in policy development
- the presence of consumer and carer feedback mechanisms for providers of care.

3. Continuity and integration of care: Seamless care throughout each consumer's journey

Continuity and integration of care refer to the system's ability to seamlessly support mental health consumers across different kinds of care throughout their journey. This ensures consumers can 'step up' and 'step down' to the supports that suit their changing needs, whether this includes primary care, community based care, hospital care, private care or care from the non-government sector. Continuity is also important to ensure a cohesive experience of care from the consumer's perspective. Under the Fifth Plan, the Commission will report on the following indicators:

- post-discharge community care
- readmission to hospital
- rates of follow-up after suicide attempt/self-harm.[57]

[57] This refers specifically to presentations to hospital that are followed up in the community within an appropriate period.

This domain includes:

- the prevalence of mental health recovery plans that promote continuity and integrated care
- private psychiatrist and GP consultations following public or private hospital discharge
- the proportion of admitted consumers who have received pre-admission care.

4. Safety, quality and responsiveness: Care that follows best practice and puts consumers first

Safety, quality and responsiveness refer to the system's ability to provide care that minimises the risk of harm, is relevant to the consumer's needs, upholds the dignity of consumers, and demonstrates best practice. Under the Fifth Plan, the Commission will report on the following indicators:

- rate of seclusion in acute inpatient mental health units
- rate of involuntary hospital treatment
- suicide of persons in inpatient mental health units.

This domain includes:

- the prevalence of incidents that result in harm to consumers of mental health services
- levels of accreditation against national mental health standards
- the prevalence of suicide in mental health care
- the extent of transparency of service provider performance and the degree to which service providers report measures to improve performance based on feedback
- the prevalence of the use of restraint
- the prevalence of prescription drug use
- the provision of gender specific wards.

Additional domains

5. Capability: A system equipped to care for consumers

Effectiveness refers to the system's core capabilities that enable high quality services and support for consumers to support overall performance of the system and ensure positive outcomes for consumers who experience mental ill health and suicidality. This domain includes: the capability levels of the mental health workforce; the performance of service provider enablers such as systems and technology; and the strength of service provider governance mechanisms (including mental health clinical governance).

6.	**Efficiency:** Providing value for money for society
	Efficiency refers to the system's ability to achieve desired outcomes with the most cost effective use of resources. This ensures the system extracts the maximum value from funding inputs, and is able to keep the cost of service provision low. This domain includes: technical efficiency of provision (across both hospital and community care), and the average cost of supports (across both hospital and community care).
7.	**Sustainability:** A system that can meet future needs
	Sustainability refers to whether the system's inputs and infrastructure are sufficient to respond to emerging needs and ensure quality services can be provided in the long term. This includes both funding inputs and workforce inputs. This domain includes: the level of funding for mental health supports, the strength of mental health workforce planning, the level of investment in workforce training, and the level of investment in mental health research (including research translation) and innovation.

Population domains

Potential 'population' domains of the Framework will measure the mental health status and quality of life of people in Australia. Population domains are described in Table 4.

Table 4: Population domains

Population
Focus domains (over the next five years)
1. Prevalence of diagnosable mental ill health, suicide and suicide attempts: Building a mentally healthy population
This domain measures the number of people in Australia who have a diagnosable mental ill health or experience of suicidality, as well as the population rates of suicide. Although measures of change in mental ill health prevalence are not updated it is important for the Framework to consider prevalence to understand the extent of mental ill health and suicidality in Australia. Under the Fifth Plan, the Commission will report on the following indicators: • prevalence of mental ill health • proportion of adults with very high levels of psychological distress • rates of suicide and self-harm. This domain includes: • the prevalence of self-reported positive mental health and wellbeing • the rates of attempted suicide.
2. Mental health outcomes: Improving the mental health and wellbeing of people with lived experience
This domain measures the mental health outcomes for people in Australia who experience mental ill health or suicidality. Monitoring and reporting on this domain will be supported by the roll out of the Your Experience of Service (YES) survey, which includes a range of patient-reported experience measures (PREMs) as well as a number of patient-reported outcomes measures (PROMs).[58] Under the Fifth Plan, the Commission will report on the following indicators: • long-term health conditions in people with mental ill health • mortality gap for people with mental ill health (which refers to average life expectancy

[58] Mental Health Services in Australia, Australian Institute of Health and Welfare. YES survey – sample survey instrument. Accessed September 2017 from <https://mhsa.aihw.gov.au/committees/mhissc/YES-survey/>

compared to the broader population)

- proportion of consumers and carers with positive experiences of service provision
- changes in the clinical outcomes of mental health consumers.

This domain includes:

- the proportion of consumers who report PROMS
- mental health outcomes for people with mental ill health and psychosocial disabilities
- the mortality rate of people will a mental ill health (compared to the broader population).

3. Broader quality of life outcomes: Thriving, not just surviving

This domain measures the broader factors that support a contributing life for people who experience mental ill health and suicidality in Australia. It is important for the Framework to capture these quality of life factors to enable a broader understanding of health and wellbeing from the consumer's perspective. Future monitoring and reporting will be supported by the new Living in the Community Questionnaire, which surveys a number of aspects of a contributing life. Under the Fifth Plan, the Commission will report on the following indicators:

- rate of drug use in people with mental ill health
- avoidable hospitalisations for physical illness in people with mental ill health
- connectedness and meaning in life
- rate of social/community/family participation amongst people with mental ill health
- proportion of people with mental ill health in employment
- proportion of carers of people with mental ill health in employment
- proportion of mental health consumers in suitable housing
- experience of discrimination in people with mental ill health.

This domain includes:

- the proportion of people in prison with mental ill health
- the prevalence of alcohol and tobacco abuse amongst people with a mental ill health
- the presence of comorbid chronic physical health conditions of people with mental ill health.

Priority groups

In addition to considering mental health outcomes at a general population level, it is also important for the Framework to consider specific priority groups that have different experiences of mental health when compared to the general population. These priority groups are described in Table 5. The Commission will disaggregate available information by priority group. For example, the Commission will report on the prevalence of suicide for the general population, but also specifically for Aboriginal and Torres Strait Islander people.

Table 5: Priority groups

Priority groups
Priority groups (over the next five years)
1. Aboriginal and Torres Strait Islander people
Aboriginal and Torres Strait Islander mental health is a national policy priority due to its marked disparity against general population mental health. On average, Aboriginal and Torres Strait Islander people have higher exposure to mental ill health risk factors such as discrimination, imprisonment and substance abuse.[59] These factors can also lead to problems of intergenerational disadvantage amongst Aboriginal and Torres Strait Islander people.
2. Culturally and Linguistically Diverse communities
Culturally and linguistically diverse (CALD) communities include people who recently migrated to Australia or whose family has done so. Migration to a new culture can often create or exacerbate mental distress, including mood disorders and anxiety.[60] Furthermore, cultural and language barriers can impede a consumer's ability to navigate the mental health system, including the ability to access and receive appropriate supports.
3. Children and young people
Childhood health outcomes can have significant and enduring effects on a person's ongoing development and their health outcomes later in life. This is a critical period of development, noting that a first episode of psychosis is most likely to occur in late adolescence or in the early adult years. It is therefore important for the Framework to monitor and report on the mental health and development of children and young people to understand how factors such as physical development, perinatal health, trauma and access to supports affect their outcomes. Under the Fifth Plan, the Commission will report on the following indicator: • Proportion of children developmentally vulnerable in the Australian Early Development Index.

[59] The National Mental Health Commission. Contributing Lives, Thriving Communities. 2014.

[60] Khawaja NG et al. Characteristics of culturally and linguistically diverse mental health clients. 2013.

4. Older people
Older people often face changing social determinants that can negatively impact their mental health. This includes changes to employment as they transition to retirement, accompanying changes in their economic status and potential loss of social and community connections. Furthermore, older people have an increased risk of chronic physical health issues which are a risk factor for mental ill health.
5. People with a dual disability and dual diagnosis
People living with a dual disability (co-occurring disability and mental ill health) or dual diagnosis (co-occurring drug and alcohol issues along with mental ill health) include, for example, people with an acquired brain injury (ABI) who also experience mental ill health. It can be difficult to obtain support for people living with a dual disability or dual diagnosis, as services are often provided separately for each of the co-occurring issues. Mental ill health can increase risks associated with a brain injury, for example, including increased risk of social isolation, family breakdown, unemployment, aggression and risk of exploitation.[61]
Additional population groups
6. Defence personnel and veterans
Defence personnel and veterans are at a higher risk of stress disorders (including post-traumatic stress disorder), depression, anxiety and substance abuse than the general population.[62] This can be related to traumatic experiences whilst in service, physical and chronic injuries and the transition from the military into civilian life.
7. Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and Intersex (LGBTQI) people
LGBTQI people have been shown to on average have poorer mental health than the general population, including a higher risk of depression, anxiety, self-harm and suicide.[63] This is often driven by factors such as violence and discrimination which can result in and exacerbate mental ill health.

[61] Brain Injury Australia. (2007). Complexities of co-morbidity (acquired brain injury and mental ill health) and the intersection between the health and community services systems. Retrieved, 18 August, 2009, from http://www.braininjuryaustralia.org.au/docs/FaCSIA%20-%20ABI%20-%20Mental%20illness%20Dual%20DisabilityPaper-%202007_final.pdf

[62] Department of Veteran Affairs. Veteran Mental Health Strategy - A Ten Year Framework 2013 – 2023. Commonwealth of Australia. 2013.

[63] Leonard W et al. Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians. 2012.

8. Refugees

Refugees are also at risk of the mental distress factors associated with migration, but are also likely to have experienced traumatic circumstances that further increase their risk of mental ill health. It is therefore important for the Framework to specifically consider the mental health status of refugees in Australia.

9. Rural and remote populations

Rural and remote populations have different experiences of mental ill health compared to urban areas, including higher rates of suicide and higher rates of alcohol misuse.[64] This is related to social determinants such as regional economic factors and potential for social isolation due to geographical distance. Furthermore, lower levels of service access in rural and remote areas can impact overall mental health outcomes.

[64] The Royal Australian and New Zealand College of Psychiatrists. Mental health in rural areas. Accessed 25 August 2017.

Opportunities for the Commission to add value through analysis

The Commission will consider how to source and analyse data. This section outlines a number of approaches the Commission could use.

Data linkage has the potential to significantly increase the power of existing mental health and suicide datasets

Many experts and organisations in the mental health and broader health system recognise the potential for data linkage to increase the value of existing data. The Commission has previously explored data linkage activities with the Australian Bureau of Statistics (ABS). The Framework could aim to strategically guide future linkage activities promoting further efforts to link existing datasets (including housing, ageing, disability, labour force, private health insurance, and mental health service provision).

The Commission can encourage others to address data gaps and linkage

As a secondary user of data, the Commission could enhance monitoring and reporting on mental health and suicide prevention through working with data custodians to consider further work to utilise longitudinal data, cross-sectional data, qualitative data, consumer and carer data, and outcome data.

The Commission could also consider commissioning other organisations to directly address priority data gaps and explore data linkage.

The Commission could add value by analysing data at a national, jurisdictional and sub-jurisdictional level as appropriate

The Commission will provide an aggregated national picture of mental health and suicide in Australia, but can also provide information on what is occurring at the jurisdictional and sub jurisdictional levels. This analysis could serve to provide comparisons, highlight areas of best practice, as well as identify opportunities to drive improvements at the regional level

There is an opportunity for the Commission to use unique primary data sources

There may be opportunities for the Commission to use unique, technology-enabled data sources to support future monitoring and reporting. These data sources may include social media data and google search analytics. These potential data sources will be explored and assessed further once the draft Framework is finalised.

Further, a majority of data analyses in the current monitoring and reporting landscape focus on quantitative data. The Commission could include qualitative analyses and case studies including stories of lived experiences from consumers, carers, families and support people.

Flexible reporting

The Commission intends to report on mental health and suicide prevention in a variety of formats and use the data to tell a story. An important aspect of this is consideration of the level of detail and information required according to the audience. Potential reporting formats are outlined in Figure 4.

Figure 4: Potential monitoring and reporting formats

- **Media release:** overview of key information
- **Visuals and infographics (online/hard copy):** to help communicate findings through social media
- **Videos:** auditory and visual way to convey insights from analysis and reports
- **Interactive data:** allows users to customise their own graphs
- **Topical reports (online/hard copy):** provides detailed findings on specific topics within mental health and suicide
- **Annual report (online/hard copy):** provides detailed findings
- **Data cube:** Downloadable data that allows data manipulation and personal use
- **Technical note:** describes the method and technical terms used reports

Online formats can include downloadable PDF reports, visuals, and infographics, as well as interactive annual reports hosted via a micro-site.[65] Different audiences tend to be interested in varying levels of detail. For example, the general public frequently engages best with short and sharp messaging, while academics and service providers are often interested in deeper levels of analysis and detail. All audiences tend to find interactive reports and data analytics tools appealing and audiences value being able to dip in and out of information easily. Some would find immense value in raw data sets to produce their own tailored analysis. It is important to note that a significant impact on reporting is the availability of data.

Consultation questions

You may wish to consider the following questions to guide your input into the development of the Framework:

1. What are the mental health monitoring and reporting priorities in your community, region or jurisdiction?

[65] In this context, 'micro site' is a website completely dedicated to a report. See, for example, the Salvation Army's 2016 Annual Report at www.salvationarmyannualreport.org/

2. What information gaps are there in the current mental health and suicide monitoring and reporting landscape?

You may also consider these additional questions if your organisation currently monitors and reports on mental health and suicide prevention:

3. What data do you currently use for monitoring and reporting mental health and suicide prevention?
4. What areas are you prevented from reporting on due to limitations such as a lack of available data?

Appendix D Environmental Scan Insights Paper

Summary of key findings

The National Mental Health Commission (the Commission) engaged Nous Group (Nous) to develop a multi-year national monitoring and reporting framework (Framework) for mental health and suicide prevention. The Framework will enable value-add reporting, instigate change and support the Commission to pursue its mission and core purpose.

This Environmental Scan Insights Paper (Paper) proposes initial factors for the Commission to consider in determining how it can best add value and instigate change through its Framework. The Paper analyses the current Australian mental health and suicide prevention policy and reform context and the current mental health and suicide prevention monitoring and reporting landscape. It also incorporates insights from an environmental scan of international mental health monitoring and reporting to identify lessons that can be applied to the Australian context.

The analysis to date has identified three overarching considerations for the Commission which are summarised below. The rest of the Paper provides the detailed analysis and evidence that supports these considerations. These include:

1. The Commission has a unique role in national monitoring and reporting of mental health reforms and can use this as an opportunity to instigate change.
2. There are specific considerations and opportunities for how the Commission can add value through its monitoring and reporting.
3. Design principles will ensure the Commission's Framework is fit for purpose and can deliver value in the current landscape.

1. The Commission has a unique role in national monitoring and reporting of mental health and suicide prevention and can use this as an opportunity to instigate change

The Commission was established in 2012 to provide independent reports and advice to the community and government on strengths and priorities for change in Australia's mental health system. The Commission's core functions are to influence system improvement and better accountability through leading, collaborating, advising, and reporting.

The Commission is the only organisation in Australia with this mandate at a national level. This presents the Commission with unique opportunities to be a catalyst for change across a variety of settings:

The Commission can present an integrated, national perspective of mental health trends and issues | There is currently no comprehensive national overview of mental health and suicide prevention. The Commission is ideally placed as a national authority to do so, with an ability to foster connections and innovations between different governments and health and social service delivery settings to deliver positive outcomes for Australians with mental health issues, their families and carers and the broader Australian community.

The Commission can use its role as an independent advisor to leverage its monitoring and reporting function to drive reform | The Commission's mandate to be independent and influence reform uniquely enables it to push beyond simply describing the current state of national mental health. Instead, it can make action-oriented and practical recommendations across the mental health system for national level issues.

The Commission can drive the realisation of person-centric mental health services | The Commission can use its monitoring and reporting role to amplify and support the voice of consumers, carers, families, and support people to ensure services are shaped to the needs of the end user.

The Commission can influence data collection and data linkage | Given its national leadership role in monitoring and reporting, the Commission has an opportunity to influence and advise how data sets are collected and linked. There is an opportunity for the Commission to highlight issues relating to an absence of statistical linking keys, varying custodians for different datasets, general data gaps and the lack of linkage being carried out. All of these issues prevent a comprehensive understanding of the mental health system.

2. There are specific considerations and opportunities for how the Commission can add value through its monitoring and reporting

This Paper distils a number of specific considerations for the Commission's future Framework and presents some preliminary opportunities. An overview of these considerations and opportunities are provided in Table 7 overleaf and further analysis is captured in the main body of this report.

Table 7: Overview of the considerations and opportunities for the Commission to add value through monitoring and reporting

Report section	Considerations for the Commission when determining the focus of its monitoring and reporting
What main topics are organisations monitoring and reporting on in mental health and suicide prevention?	1. Consider how to avoid duplication and fill the gaps in existing national reporting, which focus on the following topics: • awareness and stigma • prevention • levels of consumer, carer, family, and support peoples' participation in delivery of care • physical health • quality of life. 2. Consider how to bring together the insights on mental health and suicidality that exist at both a national, state and territory, and regional level.
What population groups do the current mental health and suicide prevention frameworks focus on?	3. Consider focused monitoring and reporting on specific population groups. The current population groups who are monitored to varying degrees include: • children and young people • people in the justice system • rural and remote populations • Aboriginal and Torres Strait Islander people • people who are homeless.
Report section	**Opportunities for the Commission to add value through monitoring and reporting**
What type of data is used to monitor mental health and suicide prevention?	4. Combine qualitative data with quantitative data to tell a richer story about the Australian mental health system, with a focus on the experience of consumers, carers, families and support people. 5. Focus on including outcomes measures to complement measures of inputs, processes and outputs, with a focus on consumer, carer, family, and support people's reported outcomes. 6. Analysis of the impact of activities undertaken within the social services and justice sector on mental health and suicide prevention.
How is data analysed to produce insights in the current landscape?	7. Consider opportunities to maximise the value of existing data through sophisticated, context-relevant analysis and data linkage. 8. Use indicators that can be maintained and monitored over the long-term to enable longitudinal analysis and reveal systemic changes. 9. Benchmark differences between jurisdictions and population groups to highlight examples of successful initiatives and specific challenges to address.
What format and frequency is mental health and suicide prevention reporting conducted?	10. Identify different audiences and determine how monitoring and reporting can be tailored for each audience, including the varied frequency of reporting. 11. Use digital formats that supplement traditional text-based reports (for example, e-books and interactive web-enabled tools). 12. Create user-friendly summaries such as factsheets and infographics.

Report section	Opportunities for the Commission to add value through monitoring and reporting
To what extent is current mental health monitoring and reporting aligned to its policy and reform agenda?	13. Develop policy-relevant analysis (for example, monitor how service access and services changes are impacted by the introduction of the NDIS and PHNs) synchronised with budget and policy cycles 14. Promote person-centred monitoring and reporting through: • an increased focus on consumer-reported measures • an increased focus on consumers, carers, families and support people experiences of care, outcomes and preferences • reports that are accessible for consumers, carers, families and support people and empower them to hold the mental health system to account 15. Contribute towards stronger reporting on: • prevention and early intervention • local interventions and regional performance • mental health of Aboriginal and Torres Strait Islander people • mental health of LGBTQI people and communities • other priority population groups • integrated and coordinated care • accessibility of care • prevalence of mental illness.
What can we learn from international models for monitoring mental health?	16. Look beyond clinical outputs and outcomes and include indicators around quality of life and experiences of care. 17. Consider context that impacts interventions (for example, difference between state and territory policies) to enable meaningful comparisons. 18. Outline the principles that determine the selection of indicators for the Framework, including the timeliness, clarity and assessments of the consumers, carers, families and support peoples' needs. 19. Include and distinguish between tactical and strategic indicators. Tactical indicators are often short-term process measures, and strategic indicators are often long-term outcome measures. This will enable the audience to understand when they can expect indicators to signal progress against the implementation of a strategy, for example. 20. Consider the full cycle of care for mental health issues (for example the framework shouldn't focus solely on acute intervention). 21. Design a reporting dashboard that is accessible and easily digestible by a range of audiences, including consumers, carers, families and support people and people outside of the mental health sector. For example, include a summary table of progress against indicators that are colour coded to signal whether there is desirable, undesirable or no change against an indicator. 22. Consider a more prominent focus on sub-population groups (for example, LGBTQI, Aboriginal and Torres Strait Islander, culturally and linguistically diverse)

3. Design principles will ensure the Commission's Framework is fit for purpose and can deliver value in the current landscape

Design principles are an important aspect of any framework, as they anchor the design process and ensure the purpose and focus of the Framework are met. The indicative design principles in Figure 6 summarise the themes that have emerged from the environmental scan. These indicative design principles will continue to evolve as the Framework is developed.

Figure 6: Indicative design principles for the Commission's Framework

1. Person-centred

The variety of consumer perspectives and needs should be at the centre of the Framework. It should represent a whole-of-life perspective and consider wider determinants of health and wellbeing.

2. Aligned to policy and reform priorities

The framework should support national policy and reform priorities and monitor their impact to hold the system to account.

3. Tailored to target audiences

The Framework should have a clearly defined monitoring and reporting audience and tailor its reporting to their varying needs.

4. Innovative

The Framework should consider opportunities to use diverse data sources beyond those already being used to monitor and report on mental health.

5. Flexible

The Framework should be flexible and be able to respond to new and emerging issues, while maintaining the ability to monitor specific issues over time.

6. Nationally and locally minded

The Framework should enable the Commission to drive change at the national level, but also monitor change at the local and regional level.

7. Consider specific population groups

The Framework should capture the perspectives and needs of population groups who are particularly vulnerable or have unique needs.

8. Balanced and diverse indicators

The Framework should have a small, focused group of measures that balance inputs, processes, outputs and outcomes, and combine quantitative and qualitative data.

Introduction

Purpose of the project

The Commission engaged Nous to develop a monitoring and reporting framework for mental health and suicide prevention over a multi-year timeframe. The Framework will enable value-add reporting, instigate change and support the Commission to pursue its mission and core purposes of:

- independent national monitoring and reporting on key issues in mental health and suicide prevention
- collaborating and advising, and
- being a catalyst for change, including by influencing national policy debates, decision making and outcomes.

The Commission's monitoring and reporting on mental health and suicide prevention should enable insight into outcomes for people with a lived experience of mental illness and suicidality, their carers, families, friends and support people. It should explore all areas of a contributing life, hold organisations to account and influence change in policy and practice to improve mental health outcomes.

Objectives of the Framework

The objectives of the Framework are to:

- add value beyond current mental health and suicide prevention reporting, instigate positive change and enhance the Commission's influence
- avoid duplication with other monitoring and reporting in mental health and suicide prevention
- enable a more systematic and innovative approach to collecting, analysing, reporting and leveraging information
- achieve policy relevance and respond to changing priorities, but also maintain consistency over time of core elements of the Framework to enable longitudinal analysis
- report on sectors beyond health that impact on mental health
- encompass inputs, processes, outputs and outcomes
- analyse and extract insights from both qualitative and quantitative information
- have strong stakeholder buy-in and be accessible to multiple audiences through various methods of reporting.

Purpose of this Paper

This Paper comprises insights on national mental health policy and monitoring and reporting frameworks that will inform and contribute to the development of the Commission's Framework. It highlights opportunities where the Commission could add value in the current monitoring and reporting landscape. The Paper's insights are derived from an environmental scan from the following key sources:

- documents relating to the current monitoring and reporting activities across mental health and suicide prevention from Australia and internationally, and
- documents relating to Australia's broader mental health and suicide prevention policy and reform agenda.

The objectives of this environmental scan are:

- to conduct a baseline analysis of the current state of mental health and suicide prevention monitoring and reporting in Australia
- to explore how monitoring and reporting is conducted in other countries, and to explore other opportunities or methods to monitor and report in Australia, and
- identify where there is potential for the Commission to add value through addressing specific gaps or areas of weak analysis and reporting.

The feasibility of the options outlined in this report will be interrogated through consultation and the development of the draft Framework. This Paper does not aim to describe what the Commission's future mental health and suicide prevention monitoring and reporting framework should entail.

The insights are structured in this report under the following sections:

- Key themes in Australia's mental health policy and reform environment
- Current state of Australian monitoring and reporting on mental health and suicide prevention
- Insights from international models monitoring mental health and suicide prevention

Nous will continue to develop these insights through further data sources, including interviews, national workshops and the public consultation website.

What are the key themes in Australia's mental health policy and reform agenda?

There are a number of national initiatives and policies driving reform in mental health and suicide prevention in Australia. These are captured at a high level in this section. The main policies and initiatives driving mental health reform are included – it is not an exhaustive list of all national mental health and suicide prevention policies and initiatives. There are several recurring focuses or themes[66] that feature in the different policies, which are outlined in Figure 7.

Figure 7: Recurring themes in Australia's mental health and suicide prevention policies and reforms

Characteristics of care	
Person centred	The right care at the right time, delivered in diverse settings, that respond to the needs of the consumer.
Integrated and coordinated	Integrated and coordinated care across health and social domains (including education and disability care) and in all settings (i.e. stepped care).
Accessible	Care that is easy for consumers to request and receive.
Safe and quality	Care that is safe for the consumer and of a high quality.
Local interventions	Local and regional planning and service delivery that reflects the context of the community.
Specific population groups	
Aboriginal and Torres Strait Islander	Approaches to care that reflect the unique cultural and spiritual needs of Aboriginal and Torres Strait Islander people and communities.
LGBTQI	Approaches to care that reflect the specific needs of LGBTQI people and communities.
Broader initiatives	
Suicide prevention	Investment in services and approaches that support the prevention of suicide.
Stigma reduction	Reduction of the stigma that can be associated with mental health issues.
Prevalence of mental health	The mapping of prevalence of mental health.
Prevention and early intervention	Services and approaches that facilitate prevention and early intervention.

[66] Key themes are the themes that have been captured across more than one major policy and/or initiative.

The direction of policy over recent years represents a drive to put consumers at the centre of care, and to create a more informed, proactive, flexible and integrated system. The need for an integrated system extends beyond the mental health sector, with disability, housing, employment and education sectors increasingly seen as crucial to achieve comprehensive mental health and suicide prevention care. Table 8 provides an overview of the main national mental health and suicide prevention policies, their purpose and main themes.

Table 8: Focus of key Australian mental health and suicide prevention policies

	Policy / strategy	Overview	Key themes[67]
Policies / initiatives targeted solely at mental health	**The National Mental Health Strategy**[68]	Strategy that aims to promote the mental health and well-being of the Australian community, reduce the impact of mental disorders on individuals, families and the community, and assure the rights of people with mental illness. It also aims to prevent the development of mental disorder. It includes the National Mental Health Policy, the first four National Mental Health Plans, and the Mental Health Statement of Rights and Responsibilities.	Prevention and early intervention Person centred care Accessible care Stigma and discrimination Recovery from mental health problems Rights of people with mental health issues Participation of people with mental health problems Integrated and coordinated care Support for carers Safe and quality care Prevalence of mental health LGBTQI communities Aboriginal and Torres Strait Islander people
	The National Suicide Prevention Strategy[69]	Strategy that provides a platform for Australia's national policy on suicide prevention. It involves a systems-based regional approach to suicide prevention, national leadership and support activity, preventing suicide in Aboriginal and Torres Strait Islander communities, and a joint commitment by all Australian Government states and territories to prevent suicide and ensure effective follow-up support.	**Suicide prevention** Local interventions Prevention and early intervention Integrated and coordinated care Aboriginal and Torres Strait Islander LGBTQI Person centred care

[67] Bolded themes in Table 8 signal an overarching theme for the policy that acts as a lens for the sub-themes (non-bolded) below it. For example, an overarching theme might be 'Aboriginal and Torres Strait Islander' while the sub-theme is 'suicide prevention'. This means the policy is focused on the suicide prevention of Aboriginal and Torres Strait Islander people. Note that not all policies / initiatives have an overarching theme, and are instead focused on improving mental health in the broadest sense.

[68] The Department of Health, (1992). National Mental Health Strategy. Accessed online 24 July 2017 http://www.health.gov.au/internet/main/publishing.nsf/content/mental-strat

[69] The Department of Health, (2015). National Suicide Prevention Strategy. Accessed online 24 July 2017 http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-nsps

	The Fifth National Mental Health and Suicide Prevention Plan *(under development)*[70]	Plan to establish a national approach for collaborative government effort in mental health over the next five years.	Integrated and coordinated care Local interventions Person centred care Suicide prevention Aboriginal and Torres Strait Islander Physical health Stigma and discrimination Safe and quality care
	The National Aboriginal Suicide Prevention Strategy[71]	Strategy to reduce the cause, relevance and impact of suicide on Aboriginal and Torres Strait Islander people, their families and communities.	**Aboriginal and Torres Strait Islander** **Suicide prevention** Person centred care Prevention and early intervention Local interventions Integrated and coordinated care
	National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Mental Health and Suicide Prevention Strategy[72]	Strategy to prevent mental ill-health and suicide, and promote good mental health and wellbeing for lesbian, gay, bisexual, transgender and intersex people and communities across Australia.	**LGBTQI** Suicide prevention Person centred care Stigma reduction Access Prevalence of mental health Accessible care
	The E-Mental Health Strategy Australia[73]	Strategy to drive an evidence based, accessible, professionally recognised and integrated e-mental health service environment.	**Technology** Accessible care Safe and quality care Integrated and coordinated care Person centred care

[70] The Department of Health, (2017). Consultation Draft for the Fifth National Mental Health Plan. Accessed online 24 July 2017 http://www.health.gov.au/internet/main/publishing.nsf/content/8F54F3C4F313E0B1CA258052000ED5C5/$File/Fifth%20National%20Mental%20Health%20Plan.pdf

[71] The Department of Health, (2013). National Aboriginal Suicide Prevention Strategy. Accessed online 27 July 2017 http://www.health.gov.au/internet/main/publishing.nsf/content/1CE7187EC4965005CA25802800127B49/$File/Indigenous%20Strategy.pdf

[72] The National LGBTI Alliance and the Department of Health, (2016). LGBTI Mental Health and Suicide Prevention Strategy. Accessed online 28 July 2017 http://lgbtihealth.org.au/wp-content/uploads/2016/12/LGBTI_Report_MentalHealthandSuicidePrevention_Final_Low-Res-WEB.pdf

[73] The Department of Health, (2012). E-mental Health Strategy. Accessed online 27 July 2017 http://www.health.gov.au/internet/main/publishing.nsf/content/7C7B0BFEB985D0EBCA257BF0001BB0A6/$File/emstrat.pdf

	The LIFE Framework[74]	Operational framework for the National Suicide Prevention Strategy that outlines the vision, purpose, principles and action areas for suicide prevention activities in Australia.	**Suicide prevention** Prevalence of mental health Building individual resilience Local interventions Prevention and early intervention Integrated and coordinated care Safe and quality care Person centred care
	Mental Health in Education Initiative (KidsMatter and MindMatters)[75]	Initiative that brings together several existing programs to create a single comprehensive service available to children and young people.	**Children and young people** Prevention and early intervention Accessible care Person centred care
	Mentally Healthy Workplace Alliance[76]	National approach by business, community and government to encourage Australian workplace to become mentally healthy for the benefit of the whole community.	**Employment** Prevention and early intervention Integrated and coordinated care Person centred care
	Closing the Gap[77]	Closing the Gap is a government strategy that aims to reduce disadvantage among Aboriginal and Torres Strait Islander people with respect to life expectancy, child mortality, access to early childhood education, educational achievement, and employment outcomes.	**Aboriginal and Torres Strait Islander** Suicide prevention Accessible care Integrated and coordinated care Local interventions Prevention and early intervention
	National Strategic Framework for ATSI Peoples Mental Health and Social Emotional Wellbeing[78]	Strategic framework for governments to respond to the high incidence of social and emotional wellbeing problems and mental ill health.	**Aboriginal and Torres Strait Islander** Suicide prevention Prevalence of mental health Person centred care

[74] The Department of Health, (2007). LIFE Framework. Accessed online 26 July 2017 http://www.health.gov.au/internet/publications/publishing.nsf/Content/suicide-prevention-activities-evaluation~background~national-suicide-prevention-strategy

[75] MindMatters (2017),*About MindMatters,* accessed online 18 August 2017 https://www.mindmatters.edu.au/about-mindmatters/what-is-mindmatters; Kidsmatter (2017), *About KidsMatter,* accessed online 18 August 2017 <https://www.kidsmatter.edu.au/about-kidsmatter>

[76] Heads up, (2015). *Creating a Mentally Healthy Workplace.* Accessed online 23 July 2017 https://www.headsup.org.au/creating-a-mentally-healthy-workplace

[77] Close the Gap Campaign Steering Committee (2017), *Progress and Priorities Report,* accessed online 18 August 2017 < https://www.humanrights.gov.au/sites/default/files/document/publication/Close%20the%20Gap%20report%202017.pdf>

[78] Aboriginal Health and Medical Research Council of NSW (2004), *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social Emotional Wellbeing,* accessed online 18 August 2017 < http://www.ahmrc.org.au/media/resources/social-emotional-wellbeing/mental-health/328-national-strategic-framework-for-aboriginal-and-torres-strait-islander-peoples-mental-health-and-social-and-emotional-well-being-2004-2009/file.html>

	National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Health[79]	Strategic framework to ensure that Aboriginal and Torres Strait Islander peoples enjoy a healthy life equal to that of the general population that is enriched by a strong living culture, dignity and justice.	**Aboriginal and Torres Strait Islander** Person centred care Local interventions Capacity building of health services and communities
Broader reforms/policies relevant to mental health	**The National Disability Insurance Scheme (NDIS)**[80]	Individualised packages to support people with disability, their family and carers. Some consumers with psychosocial disabilities are eligible for support through the NDIS.	**Disability** Accessible care Integrated and coordinated care Person centred care
	Primary Health Networks (PHNs)[81]	Primary health care organisations established to increase the efficiency and effectiveness of medical services for consumers, and to improve the coordination of care. PHNs commission mental health care and support GP provision of mental health care.	**Primary health care** Person centred care Integrated and coordinated care Local interventions

[79] Department of Health and Ageing (2003), *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Health,* accessed online 18 August 2017 <http://www.health.gov.au/internet/publications/publishing.nsf/Content/oatsih_implementationplan2007-2013~Introduction>

[80] *National Disability Insurance Act* (2013)

[81] The Department of Health, (2016). Primary Health Networks. Accessed online 26 July 2017 <http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Home>

Current state of Australian monitoring and reporting

Many organisations contribute to the mental health and suicide prevention monitoring and reporting landscape in Australia. It is important for the Commission to understand what the current landscape looks like to identify how its monitoring and reporting can best add value and instigate change in the mental health system.

The following section of this report provides an overview of the Australian mental health and suicide prevention monitoring and reporting landscape and assesses its strengths and weaknesses. It then presents opportunities for where the Commission's Framework could add value in this context.

What is the current state of monitoring and reporting in Australia?

The following section of this Paper provides insights derived from a scan of the key mental health and suicide prevention monitoring and reporting activities that are currently carried out in Australia.

What monitoring and reporting does the Commission currently conduct?

The role of the Commission is to provide insight, advice and evidence on ways to continuously improve Australia's mental health and suicide prevention systems, and act as a catalyst for change to achieve those improvements. This includes increasing accountability and transparency in mental health through the provision of independent reports and advice to the Australian Government and the community.

Since its establishment in 2012, the Commission has annually released a national report on mental health and suicide prevention in Australia to provide independent advice to the Australian Government and promote greater accountability and transparency in the mental health system. Past reports have ranged in format, including Report Cards with recommendations in 2012 and 2013, a report-back against those recommendations in 2014, and Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services (the 2014 Review), which was released in 2015. Figure 8 summarises the Commission's recent reporting activities.

Figure 8: Overview of the Commission's recent reporting activities

National Report Cards	National Review of Mental Programmes and Services	Spotlight Reports	Australian Defence Force Review	Expert Reference Group on Mental Health Reform
An annual series of reports on mental health and suicide prevention.	• 25 recommendations to create a more supportive, holistic mental health system. • A detailed implementation activity and plan for action in mental health reform.	Reports commissioned to highlight and inform on issues and areas of interest raised by the Commission.	Review of the services available to veterans and members of the Australian Defence Force in relation to the prevention of self-harm and suicide.	• Provides advice to the COAG working group on Mental Health Reform. • Developed a framework of targets and indicators for Mental Health Reform.

What other organisations in Australia monitor and report on mental health and suicide prevention?

In addition to the Commission, many organisations contribute to the mental health and suicide prevention monitoring and reporting landscape in Australia. Nous scanned the key organisations and frameworks that contribute to mental health and suicide prevention monitoring and reporting to understand how the Commission can add value within the current landscape.

Overall, the purpose of the state mental health commission reports is generally to demonstrate progress against long term strategic plans, whereas Commonwealth Departments and Agencies focus on providing recurrent reporting on service performance and system-level changes.

Table 9 summarises these key organisations and frameworks.

Table 9: Key monitoring and reporting organisations and frameworks in Australia

	Organisation	Monitoring and reporting framework	Purpose of the framework	Frequency of reporting
Mental health commissions	**National Mental Health Commission**	Contributing Lives, Thriving Communities (2014, active)	To develop a small number of agreed targets for government that are high-priority, ambitious and achievable	Annual
	Potentially the National Mental Health Commission - to be confirmed[82]	Draft Fifth National Mental Health Plan (2017, active once finalised)	To monitor and report on the progress of sector reform, and support the mental health system towards improved consumer and carer outcomes	TBC
	Queensland Mental Health Commission	Performance Indicators (2015, active)	To report on the six long-term outcomes of the Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019	Annual
	NSW Mental Health Commission	Living Well: A Strategic Plan for Mental Health in NSW in 2014-2024 (2014, active)	To report on progress against the Living Well strategic plan for mental health in NSW, 2014-2024	Annual
	Western Australia Mental Health Commission	Better Choices Better Lives: Western Australian Mental Health, Alcohol and other Drug Service Plan 2015-2025 (2015, active)	To report on progress against the 'better choices, better lives 2015-2025' plan.	Annual

[82] The Fifth National Mental Health Plan is currently in its draft from, and indicates an intention for the National Mental Health Commission to monitor its progress once in place. Although monitoring and reporting against the Fifth National Mental Health Plan is not yet occurring and therefore does not currently contribute to the monitoring and reporting landscape, we have included it in this analysis given it will soon have a significant impact on national monitoring and reporting.

Commonwealth organisations	**Department of Health**	National Mental Health Reports (2013, active)	To summarise system-level changes that have taken place in mental health since the National Mental Health Strategy in 1992	Every two – three years
	Productivity Commission	Report on Government Services (2017, active)	To report on the equity, effectiveness and efficiency of government services, including mental health services	Annual
	Australian Institute of Health and Welfare (AIHW)	Key Performance Indicators for Australian Public Mental Health Services (active, 2014)	To measure performance in a way that supports quality improvement activities at the level of mental health service organisations	Annual
	AIHW	National Mental Health Performance Framework (NMHPF) (inactive, 2005)	To facilitate a culture of continuous quality improvement in mental health service. It supports Australian and state and territory governments' commitment to improving accountability and transparency at the Mental Health Service Organisation level.	Annual

The frameworks described above reflect the key monitoring and reporting in the current Australian landscape. However, several additional frameworks are in development that will contribute to the future monitoring and reporting landscape. These include the following:

- **The National Health Performance Framework** – As a result of a recent review, the National Health Performance Framework is currently being revised and will subsume the former Performance Accountability Framework. While mental health is not a focus of the framework, mental health reporting will be included.
- **Primary Health Network (PHN) Performance Framework** – A performance framework for the PHNs is currently under development. Once developed, further information will be available on PHN performance, including the performance of mental health services.
- **Primary Mental Health Care Minimum Data Set (PMHC-MDS)** – The Commonwealth Department of Health is currently establishing the PMHC-MDS for PHNs. This will provide the basis for PHNs and the Department of Health to monitor the quantity and quality of mental health service delivery, and will inform the production of key performance indicators for these services.[83]
- **International mental health benchmarks** – Australia is closely involved in an ongoing international collaboration led by the International Initiative for Mental Health Leadership (IIMHL). The purpose of this collaboration is to facilitate international mental health benchmarking, and includes a 'deep dive' to identify key indicators that can be used for benchmarking across countries.

[83] Department of Health 2017, *About the PMHC-MDS*, Accessed 27 July 2017, <https://www.pmhc-mds.com/index.html>

- **South Australia Mental Health Commission Strategic Plan** – The South Australia Mental Health Commission is currently developing a strategic plan for 2017-2022 which will align with the priorities of the Fifth National Mental Health Plan. This will set the direction for monitoring and reporting in South Australia, and is due for completion in October 2017.[84]

State and territory health departments also monitor and report on health system performance in their respective jurisdictions and some incorporate specific domains and/or indicators related to mental health and suicide prevention. As the frameworks are not specifically focused on mental health or suicide prevention, they have not been included in Table 9. Generally, these frameworks focus on activity and the input level of health system monitoring and reporting. We will consider what these frameworks also measure in mental health and suicide prevention when developing the Commission's Framework. Some examples of these frameworks include:

- The Performance Policy Framework for Western Australia[85]
- The Performance Framework for South Australia[86]
- The Performance Framework for Queensland[87]
- The Victorian Health Services Performance Monitoring Framework[88]
- The NSW Health Performance Framework[89]

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[84] SA Mental Health Commission 2017, *SA Mental Health Strategic Plan*, Accessed 26 July 2017, <http://samentalhealthcommission.com.au/what-we-do/sa-mental-health-plan/>

[85] Government of Western Australia Department of Health 2016, *The Performance Policy Framework,* accessed online 18 August 2017, <http://www.health.wa.gov.au/circularsnew/frameworks/Performance.pdf>

[86] South Australia Health 2016, *Performance Framework 2016-17,* accessed online 18 August 2017 <http://www.sahealth.sa.gov.au/wps/wcm/connect/55c07f804bb9071dbbf9bfeb3852325e/Updated+SA+Health+Performance+Framework+16-17.pdf?MOD=AJPERES&CACHEID=55c07f804bb9071dbbf9bfeb3852325e&CACHE=NONE>

[87] Queensland Health 2016, *Delivering a High Performing Health System for Queenslanders Performance Framework,* accessed online 18 August 2017 <https://publications.qld.gov.au/dataset/e1c2648f-eb8e-4e7f-a0d7-42604cd9212f/resource/94ce3c3b-59dd-44d4-8d3c-ada71f6379bc/download/pmffinal11.8.16.pdf>

[88] Victoria State Government Health and Human Services 2016, *Victorian Health Services Performance Framework 2016,* accessed online 18 August 2017 <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorian-health-services-performance-monitoring-framework-2016-17>

[89] NSW Ministry of Health 2017, *NSW Health Performance Framework for NSW Health Services and Support Organisations,* accessed online 18 August 2017 <http://www.health.nsw.gov.au/Performance/Documents/performance-framework.pdf>

What main topics are organisations monitoring and reporting on in mental health and suicide prevention?

The current monitoring and reporting landscape covers a range of topics relating to mental health and suicide prevention. It is important to understand the extent to which different topics are currently monitored and reported (including gaps and areas of duplication) to identify opportunities for the Commission to add value. This can best be assessed by analysing the domains covered by each mental health and suicide prevention monitoring and reporting framework. Figure 9 summarises the main domains covered by the Australian monitoring and reporting frameworks and the degree to which these frameworks cover each domain. It is important to note that while these domains exist in the frameworks, the extent to which the domains are effectively monitored depends on the quality and richness of data and information available. The main domains are:

- **System inputs** – including funding levels, funding distribution, efficiency, workforce planning and research investment.
- **Access and coordination of care** – including timeliness of access, ease of access and continuity of care.
- **Quality of care** – including consumer outcomes, consumer experience of care, service quality improvement and safety.
- **Consumer and carer participation in care** – including the representation of consumers and carers in the mental health workforce.
- **Population prevalence of mental health and wellbeing** – including rates of mental illness and high psychological distress.
- **Population prevalence of suicidality** – including self-harm and rates of attempted and completed suicide.
- **Seclusion and restraint** – including seclusion, involuntary treatment and restraint.
- **Awareness and stigma**– including stigmatising attitudes and community awareness.
- **Prevention –** mental health and suicide prevention activities
- **Physical health** – including life expectancy, physical health conditions, smoking and drug and alcohol abuse.
- **Quality of life** – including social connectedness, access to suitable housing, economic participation and self-reported meaning in life.

The analysis shows gaps and areas of duplication in the current landscape. Coverage levels are assessed separately for national frameworks and the state-level frameworks (owned by the State Mental Health

Commissions) to highlight different approaches at jurisdictional levels.[90] The full heat-map analysis underlying this summary table can be found in Figure 10.

Figure 9: Summary of domain coverage by monitoring and reporting frameworks

	Domains										
	System inputs	Access and coordination of care	Quality of care	Consumer and carer participation in care	Population prevalence of mental health and wellbeing	Population prevalence of suicidality	Seclusion and restraint	Awareness and stigma	Prevention	Physical health	Quality of life
National coverage	Strong	Strong	Moderate	Weak	Moderate	Moderate	Moderate	None	None	Weak	Weak
State coverage	Moderate	Moderate	Strong	Strong	Strong	Strong	Moderate	Strong	Weak	Moderate	Strong

This analysis highlights the following insights into the topics that are reported on in the current Australian landscape:

- Quality of care is a strong focus across all frameworks. However, it should be noted that this does not necessarily mean that information is available to support effective monitoring and reporting on quality of care.
- Prevention is a notable gap across all frameworks, at both a national and state level.
- Aside from 'quality of care' and 'prevention', each domain tends to be focus at either a national or state level, but not both. This indicates that national and state reporting tends to focus on different topic areas.
  - State commission monitoring and reporting tends to focus on quality of care, population prevalence of mental illness and suicidality and broader outcomes for consumers (including stigma, physical health and quality of life). However the ability to effectively monitor and report against these domains is limited by data and information availability.
  - National monitoring and reporting, on the other hand, can be broadly characterised into two categories:

[90] It should be noted that although the monitoring and reporting frameworks in this scan function at either a national or state level, they may include sub-jurisdictional analysis. While mental health and suicidality data exists at a local and regional level (for example, see the Australian Health Policy Collaboration health tracker, which provides suicide data at the PHN and NSW Local Health District level) this data is not analysed in any of the national or state frameworks included in our scan.

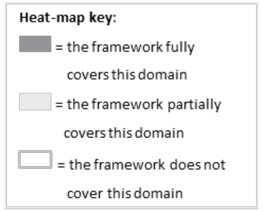
- The Contributing Lives Framework and the Draft Fifth National Mental Health Plan have similar focuses to the state monitoring and reporting frameworks.
- In contrast, AIHW, the Department of Health and Productivity Commission take a complementary system-level focus with an emphasis on system inputs, access and coordination of care and quality of care.

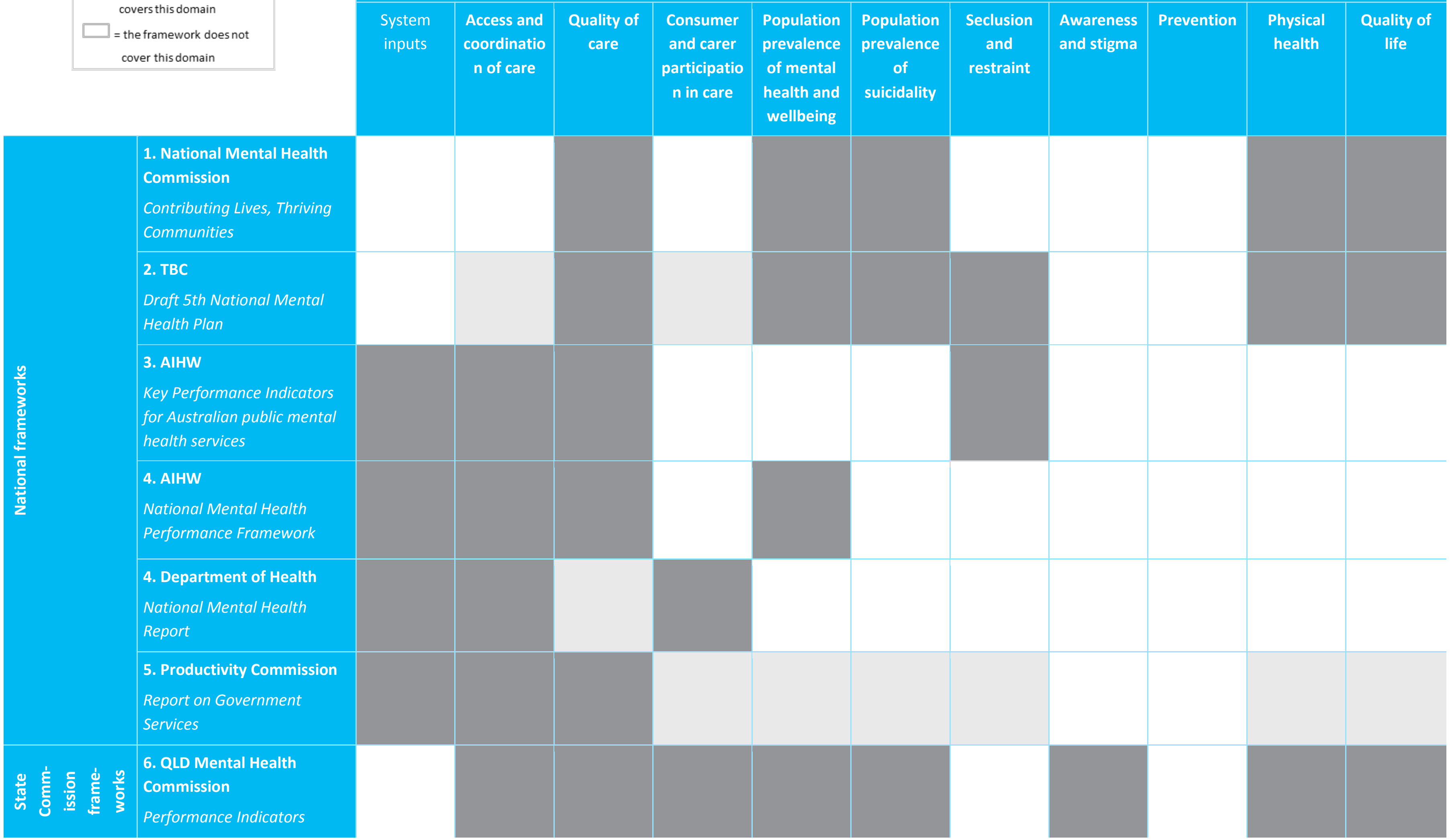
These observations on the topics covered in the current monitoring and reporting landscape raise considerations when determining the focus of its monitoring and reporting:

Considerations for how the Commission can add value through monitoring and reporting:

- Consider how to complement the existing national reporting, which focus on the following topics:
  - awareness, stigma and prevention
  - consumer, carer, families and support peoples’ participation in care
  - physical health
  - quality of life.
- Consider how to bring together the insights on mental health and suicidality that exist at both a national and a state and territory level.

Figure 10: Domains of current Australian monitoring and reporting frameworks





	7. NSW Mental Health Commission *Living well 2014-2024*											
	8. WA Mental Health Commission *Better Choices, Better Lives 2015–2025*											

What population groups do the current mental health and suicide prevention frameworks focus on?

In addition to targeted domains, many monitoring and reporting frameworks focus on specific population groups at the domain or indicator level. Figure 11 summarises these results.

Figure 11: Focus population groups in Australian mental health monitoring and reporting frameworks

	Children and young people	People in the justice system	Rural and remote populations	Aboriginal and Torres Strait Islander people	Homeless people
1. National Mental Health Commission *Contributing Lives, Thriving Communities Framework*	✓				
2. TBC *Draft 5th National Mental Health Plan*	✓				✓
3. AIHW *Key Performance Indicators for Australian public mental health services*			✓	✓	
4. AIHW *2 National Mental Health Performance Framework (2005)*					
5. Department of Health *National Mental Health Report*					
6. Productivity commission *Report on Government Services*	✓			✓	
7. QLD Mental Health Commission *Performance Indicators*				✓	
8. NSW Mental Health Commission *Living well 2014-2024*		✓			
9. WA Mental Health Commission *Better Choices, Better Lives 2015–2025*				✓	

It is evident that there is a focus on children and young people at a federal level, as well as some reporting on rural and remote populations and Aboriginal and Torres Strait Islander People.

There is less of a focus on people in the justice system, rural and remote populations and people who are homeless. While these groups may be monitored and reporting on in other sectors, this reporting may not sufficiently consider the mental health needs of these population groups.

These observations on the current state of monitoring and reporting raise considerations for how the Commission can add value to the current landscape:

Considerations for how the Commission can add value through monitoring and reporting:

- Consider focused monitoring and reporting on specific population groups. The current population groups who are monitored to varying degrees are:
  - children and young people
  - people in the justice system
  - rural and remote populations
  - Aboriginal and Torres Strait Islander people
  - people who are homeless.

What kind of data is used to monitor mental health and suicide prevention?

Nous' environmental scan made the following observations in relation to the type of data that is used to monitor mental health and suicide prevention:

- There is a strong focus on quantitative data, with a few examples of supporting qualitative case studies.
- There is thorough reporting on inputs, processes and outputs, but a gap in outcomes reporting.
- Few frameworks include patient-reported experience measures (PREMs) and patient-reported outcomes measures (PROMs).

These points are discussed in more detail below.

What type of data is used to monitor mental health and suicide prevention?

- **There is a strong focus on quantitative data, with only a few examples of supporting qualitative data, such as case studies**: Most monitoring and reporting in the current Australian landscape relies on quantitative data. However, there are some examples where reports use qualitative examples such as case studies to bring interest and a human perspective to reports. Examples include:
  - The National Mental Health Commission's Report Cards, which include quotes from Commissioners and other experts to build a case for system change, and also provide personal stories and case studies to accompany the report.
  - The NSW and WA Mental Health Commission reports, along with the Commission's latest national report, which include case studies of successful local initiatives and awareness campaigns.

    While anecdotal evidence is relevant, it is important to note that the Commission should be cautious of over-using examples that are isolated and do not represent reality in most contexts.
- **There is thorough reporting on inputs, processes and outputs, but a gap in outcomes reporting:** Most monitoring and reporting analysed in our scan demonstrated good coverage of system inputs, processes and outputs. However, there is generally a lack of reporting on outcomes, particularly at the Commonwealth level which tends to focus at the level of the mental health system. This observation has also been noted by a range of stakeholders in the sector. The information that does address consumer outcomes tends to focus at the population level (for example, changed levels of mental illness and suicidality prevalence, and reduced stigma) instead of individual-level outcomes (for example, improved treatment outcomes and consumer experiences of care).

  To enable a balanced picture across inputs, outputs and outcomes, the WA Mental Health Commission framework is explicitly structured by these three categories. This is then overlaid by different service types to produce a matrix logic (refer to Appendix E, which includes all monitoring and reporting frameworks discussed in this report).

- **Few frameworks include patient-reported experience measures (PREMs) and patient-reported outcomes measures (PROMs)**. PROMs and PREMs provide insight into the consumer's perspective of the services they receive. However, these consumer-reported measures are lacking in the current Australian landscape, with only a small number of frameworks including either PREMs or PROMs, and even fewer including both measures. Consultations indicate that more organisations will be able to report on PREMs in the future due to the new Your Experience of Service (YES) survey instrument which is being made available to service providers.
- **There is limited data collection and analysis on how mental health intersects with the social services and justice sectors.** While a lot of literature exists demonstrating the strong links between mental health issues and social services such as housing, employment, education and justice, there is limited monitoring and reporting on the relationship and impact between them. There may be an opportunity for the Commission to include this analysis in its monitoring and reporting framework, noting it will need to be targeted in its focus if it includes these sector interactions.

The observations on what data is included in the current monitoring and reporting landscape raises the following considerations for how the Commission can add value:

Considerations for how the Commission can add value through monitoring and reporting:

- Combine qualitative data with quantitative data to tell a richer story about the Australian mental health system, with a focus on consumers, carers, families and support people.
- Focus on including outcomes measures to complement measures of inputs, processes and outputs, and emphasise consumer-level and consumer-reported outcomes.
- Targeted analysis of the effect of the social services and justice sector on mental health and suicide prevention.

How is the data analysed to produce insights into mental health and suicide prevention?

Nous' environmental scan made the following observations in relation to how data is analysed:

- Low levels of analysis mean that the full value of mental health data is not being realised.
- Most reports track the movement of indicators over time, and often compare these to targets.
- There is limited benchmarking between jurisdictions and population groups.

These points are discussed in more detail below.

How is data analysed to produce insights?

- **Reports are more descriptive and do not provide great levels of analysis, and as such the full value of mental health and suicide prevention data is not being realised**. There is a limited use of analysis to produce value-adding insights from the data available in the system. For example, some reports in the landscape are oriented towards purely reporting data, such as the AIHW key performance indicators for Australian Public Mental Health Services. Other reports may provide analysis that is largely descriptive and not oriented towards instigating change in the sector, such as the Productivity Commission Report on Government Services. There is therefore opportunity for context-relevant analysis that pulls together key insights and recommendations for the sector and combines qualitative and quantitative data.
- **Most reports track the movement of indicators over time, and often compare these to targets**. The most common form of analysis in the current landscape is to track movements in indicators over time to identify areas of change. The State Mental Health Commissions often also then compare the indicators with predefined targets from their mental health strategies to introduce a second overlay of analysis. This indicates the value in tracking core indicators over multiple years to see long-term systemic changes.
- **There is limited benchmarking between jurisdictions and population groups**. Current monitoring and reporting often includes aggregated data alongside data specific to sub-jurisdictions and specific population groups: for example, the AIHW key performance indicators include indicators at a national level as well as for the states and territories and for different population groups. However, beyond this there is limited analysis to draw out comparisons across jurisdictions and population groups.
- **There is limited data linkage between Commonwealth and state and territory areas of responsibility and between health and other sectors**. A large amount of data is collected for the purposes of monitoring the health and social services sector and is collected at both a Commonwealth and state and territory level. However this data is rarely linked, which results in a lost opportunity to analyse and determine the causal link between issues or develop solutions to presented problems. Some of barriers to data linkage include the absence of statistical linkage keys and different data custodians.

These observations on how data is currently analysed raises the following considerations for how the Commission can add value:

Considerations for how the Commission can add value through monitoring and reporting:

- Consider how to maximise the value of existing data through sophisticated, context-relevant analysis and influencing data linkage.
- Establish indicators that can be maintained and monitored over the long-term to reveal large, systemic changes.
- Benchmark differences between jurisdictions and population groups to highlight examples of successful initiatives and unique challenges.

What format and frequency is mental health and suicide prevention reporting conducted?

Nous' scan made the following observations in relation to the format and frequency of reporting:

- Most monitoring and reporting frameworks lack a clearly stated target audience and do not consider the content and frequency of reporting most relevant to the audience.
- The majority of reports are published online as a PDF on an annual basis, with limited use of interactive media.
- Some reports use summaries and infographics to effectively convey key insights.

These points are discussed in more detail overleaf.

How are these insights communicated in terms of format and frequency?

- **Most monitoring and reporting frameworks lack a clearly stated target audience and do not consider the content and frequency of reporting most relevant to the audience**. A few monitoring and reporting frameworks clearly state their target audience, which generally includes policy-makers, service providers, consumer and carers. However, most frameworks do not state their target audience, nor is a clear intent demonstrated in the way information is formatted and communicated.
- **The majority of reports are published online as a PDF on an annual basis, with limited use of interactive media.** Most reports are in traditional text-based formats, sometimes accompanied by excel data tables to allow for further analysis. An example from the WA Mental Health Commission is published as both an e-book and interactive PDF PowerPoint format, which allows for easier user navigation and lends itself towards a greater use of photos and graphics.[91]
- **Some reports use summaries and infographics to effectively convey key insights.** Examples include:
    - The Productivity Commission Report on Government Services, which includes short-form summaries of the key facts in the main report
    - The NSW and QLD Mental Health Commission reports, which include highly visual summary dashboards of indicators at the start of the report to allow the user to quickly see the performance of indicators against the targets.

These observations on how insights are communicated in the current landscape raise the following considerations for how the Commission can add value:

Considerations for how the Commission can add value through monitoring and reporting:

- Identify different audiences and determine how monitoring and reporting can be tailored for each audience, including the varied frequency of reporting.
- Use digital formats that supplement traditional text-based reports (for example, e-books and interactive web-enabled tools.
- Create user-friendly summaries such as factsheets and infographics.

[91] Western Australia Mental Health Commission 2016, *Mental Health Commission 2015/16 Annual Report*, < https://issuu.com/mentalhealth81/docs/2016_mhc_annual_report_final_1>

To what extent is current mental health monitoring and reporting aligned to its policy and reform agenda?

It is critical for Australian mental health and suicide prevention monitoring and reporting to reflect and support the broader mental health policy and reform agenda. Monitoring and reporting can strengthen accountability of the objectives that have been identified within the policy and reform agenda, and therefore act as a catalyst for change. Figure 12 assesses the alignment of current monitoring and reporting against key policy and reform themes, in order of assessed alignment.

Figure 12: Alignment of current monitoring and reporting to the policy and reform agenda

Key themes from the policy and reform agenda	Monitoring and reporting alignment	Comments
Suicide prevention | Investment in services and approaches that support the prevention of suicide.	Strong	There is strong reporting on suicidality at a national level, as well as by the State Mental Health Commissions. There may be further opportunities to refine this reporting, such as through focused investigations into particular population groups (such as Aboriginal and Torres Strait Islander people).
Safe and quality care | Care that is safe for the consumer and of a high quality.	Moderate	There is moderate reporting on the safety and quality of care due to the historic focus of Australian monitoring and reporting on program performance and compliance. However due to data availability reporting is not as strong as the level to which it is captured in various domains.
Person centred care | The right care at the right time, delivered in diverse settings, that best respond to the needs of the consumer.	Moderate	There has been a positive shift towards measuring social determinants of health, which shows an increased whole-of-life focus for consumers. However, there could be stronger representation of the consumer and carer viewpoint, including consumer-reported measures. There could also be a stronger focus on consumer-level outcomes to complement reporting on inputs, processes and outputs. There is also opportunity for reports to be more accessible to a consumer, carer, families and support people audience, to ensure policy and reforms are accountable to consumers, carers, families and support people.

Integrated and coordinated care | Integrated and coordinated care across health and social domains (including education and disability care), in all settings.	Moderate	There is currently a moderate level of reporting on coordination and continuity of care. However, there are opportunities to make this a higher priority focus area and consider coordinated care across mental health and social services.
Accessible care | Care that is easy for consumers to request and receive.	Moderate	There is some strong reporting on the accessibility of care. There could be further analysis on access to care particularly for remote and regional population groups. There could also be closer monitoring and reporting of the impact of new reforms on the accessibility of mental health care, such as the NDIS and PHNs.
Stigma reduction | Reduction of the stigma that can be associated with mental health issues.	Moderate	There is a moderate level of reporting on stigma reduction in the current landscape, which includes consumer-reported experience measures. Reporting on stigma is particularly strong at a jurisdiction level, but less so at a national level.
Prevalence of mental health | The mapping of prevalence of mental health using data to form a strong evidence base.	Weak	While there is some monitoring and reporting on the prevalence of mental illness, it tends to have particular areas of focus, e.g. LGBTQI communities and rates of suicidality. There are opportunities to capture the prevalence of all mental health issues nation-wide and there is a need for higher definition data on the prevalence of different mental illnesses and different levels of severity.
Prevention and early intervention | Services and approaches that facilitate prevention and early intervention.	Weak	There is an opportunity to more strongly focus monitoring and reporting on prevention and early intervention, including levels of investment in these services, access to these services and their outcomes.
Local interventions | Local and regional planning and service delivery that reflect the context of the community.	Weak	There is an opportunity to create better transparency and benchmarking between geographical regions (for example, PHNs) to promote successful local interventions and innovations, as well as highlight issues specific to different regions.

Aboriginal and Torres Strait Islander | Approaches to care that reflect the unique cultural and spiritual needs of Aboriginal and Torres Strait Islander people and communities.	Weak	There is an opportunity to create an increased focus on the mental health and wellbeing of Aboriginal and Torres Strait Islander people in the monitoring and reporting landscape.
LGBTQI | Approaches to care that reflect the needs of LGBTQI people and communities.	Very low	None of the monitoring and reporting frameworks in our scan include reporting on the mental health of LGBTQI people. This is a significant gap to be addressed for greater policy alignment.

There are a number of considerations for how the Commission can best add value through monitoring and reporting based on the above analysis:

Considerations for how the Commission can add value through monitoring and reporting:

- Develop policy-relevant analysis (for example: monitor how service access levels are affected by the introduction of the NDIS and PHNs)
- Promote person centred monitoring and reporting through:
  - an increased focus on consumer-reported measures
  - an increased focus on consumers, carers, families and support people experiences of care, outcomes and preferences
  - reports that are easy for consumers, carers, families and support people and empower them to hold the mental health system to account
- Contribute towards stronger reporting on:
  - mental health of LGBTI people and communities
  - prevention and early intervention
  - local interventions and regional performance
  - mental health of Aboriginal and Torres Strait Islander people
  - other priority population groups
  - integrated and coordinated care
  - accessible care
  - prevalence of mental illness.

What can we learn from international models monitoring mental health and suicide prevention?

Mental health is monitored and reported to varying degrees worldwide. Figure 13 captures a selection of examples of monitoring and reporting across health and mental health from other jurisdictions and outlines the key insights that could contribute to the development of the Commission's Framework.

Figure 13: Insights from international models

Opportunities and benefits

International

International Consortium of Health Outcomes Measurements (ICHOM)

- Patients are included directly in the process with physicians to develop outcomes.
- Outcomes are measured by condition (e.g. diabetes) rather than specialty (e.g. podiatry) or intervention (e.g. eye examination)
- Measures the full cycle of care for the condition and tracks the patients health status after care is completed.
- Outcomes that matter for patients fall into three tiers and addressing all three can help achieve reduced costs

1. Health status achieved
2. Nature of care cycle and recovery
3. Sustainability of health

Opportunities and benefits:

Measure outcomes related to health status achieved, nature of care cycle and sustainability of health

Measure the full cycle of care for the condition

Canada

Mental Health Indicators for Canada

- Monitors and reports against thirteen domains that map directly to the priorities identified in The National Mental Health Strategy for Canada. There are between two to twelve indicators per domain.
- Reporting against domains is measured as 'good performance / desirable change', 'no change/some concern/uncertain results', and 'significant concerns / undesirable change'
- The reporting dashboard is highly visual, simple and easy to understand.

Alberta Health Services

- Two levels of indicators are employed – strategic and tactical. The strategic indicators mostly equate to outcomes and are published; the tactical indicators tend to be process measures and are where investment, programs, or quality improvement initiatives are directed to achieve strategic goals.

Opportunities and benefits:

Align monitoring and reporting to national mental health policy

Provide highly visual and digestible reports and dashboards

Develop two levels of indicators – strategic and tactical

New Zealand

Four complementary mechanisms instead of a framework, which consists of:

- Six specific health targets
- A Primary Health Organisation performance program
- Four quality and safety markers assessing patient safety
- An Atlas of Healthcare Variation showing differences across regions, organised by clinical domains

Opportunities and benefits:

Consider a more prominent focus on sub-population groups

Netherlands

Netherlands Health Performance Framework

- Domains of health status, non-healthcare determinants of health and healthcare system performance (similar to the NHPF).
- Suggests that health system performance affects health status both directly and indirectly via impacting health behaviours.
- Assesses healthcare system performance at different stages of care as well as along different domains.

Opportunities and benefits:

Consider multiple levels of indicators

United Kingdom

NHS Outcomes Framework & Clinical Commissioning Group Outcome Indicators Set

- Looks broader than clinical outcomes, including quality of life, recovery and experience of care
- Intended for providers to benchmark against each other, as well as a signal of quality to consumers
- Integrated frameworks, one measuring performance for the NHS as a whole while the latter measures performance of local delivery
- Outlines principles for selecting specific indicators, including timeliness, clarity, assessments of user needs and perceptions
- Categorises clinical indicators based on directness of connection to outcomes – health outcomes, intermediate outcomes, process measure directly linked to outcomes, process measure indirectly linked to outcomes, registers.

Outcomes Framework for Scotland's Mental Health Improvement Strategy

- Framework to support an outcome-focused and evidence- informed approach to mental health care. It is divided into three components (or tools): an outcomes triangle, logic models and multiple results chains.
- Specifies local activities that community planners can undertake to achieve outcomes for mental health and to support systematic, explicit and targeted policy development.

UK Construct for Mental Health Reporting

- Developed a common indicator for mental health and physical health

Social Services National Outcomes Framework

- Follows the principals of results based accountability – draws a distinction between well being of the population (outcomes) and service performance (difference services make to the users)
- Supported by a well-being statement: statutory requirement that defines well-being in relationship to 8 aspects of life.

Opportunities and benefits:

Outcomes should be beyond clinical and include quality of life and experience of care

Outline the principles that determine the selections of indicators

Provide practical examples of actions community planners can take to achieve outcomes

Take account of context that impacts on performance

Considerations for how the Commission can add value through monitoring and reporting:

- Look beyond clinical outputs and outcomes, and also include indicators around quality of life, and experience of care that people engaging in mental health services experience.
- Take into account context that impacts on interventions (for example, difference state and territory policies) to enable meaningful comparisons.
- Outline the principles that determine the selection of indicators that are included in the Framework, including the timeliness, clarity and assessments of the user's needs.
- Include and distinguish between tactical and strategic indicators. Tactical indicators are often short-term process measures, and strategic indicators are often long-term outcome measures. This will enable the audience to understand when they can expect indicators to signal progress against the implementation of a strategy, for example.
- Consider the full cycle of care for the mental health issues (for example the framework shouldn't focus solely on acute interventions).
- Design a reporting dashboard that is accessible and easily digestible by a range of audiences including consumers, carers, families and support people and people outside of the mental health sector. For example, include a summary table of progress against indicators that are colour coded to signal whether there is desirable, undesirable or no change against an indicator.
- Consider a more prominent focus on sub-population groups (LGBTQI, Aboriginal and Torres Strait Islander, culturally and linguistically diverse communities)

Appendix E Organisations and frameworks monitoring and reporting on mental health and suicide prevention

The following table lists key Australian mental health and suicide prevention monitoring and reporting frameworks that informed the findings of the current state environmental scan (see Appendix C).

Please note that this table does not capture the entirety of current Australian mental health and suicide prevention monitoring and reporting, given the broad range of reporting in the current landscape. The Commission would also like to recognise the following monitoring and reporting activities:

- The monitoring and reporting of State and Territory health departments
- The reporting of not for profit organisations
- The reporting of State and Territory Chief Psychiatrists.

Organisation	Monitoring and reporting framework	Purpose of the framework	Frequency of reporting
Mental health commissions			
National Mental Health Commission	National Review of Mental Health Programmes and Services (2014, a report commissioned by the Federal Government)	To develop a small number of agreed targets for government that are high-priority, ambitious and achievable	Annual
National Mental Health Commission	A Contributing Life: National Report Card on Mental Health and Suicide Prevention (2012, 2013, inactive)	To report nationally across the five domains of a contributing life to drive continuous improvement.	Annual
The Council of Australian Governments	Draft Fifth National Mental Health and Suicide Prevention Plan (2017, active once finalised)	To monitor and report on the progress of sector reform, and support the mental health system towards improved consumer and carer outcomes	TBC
The Council of Australian Governments	National Targets and Indicators for mental health reform (2013, inactive)	To provide a set of ambitious and achievable national, whole of life, outcome-based indicators and targets for mental health that will be understood by the community and drive systemic change.	NA
Queensland Mental Health Commission	Performance Indicators (2015, active)	To report on the six long-term outcomes of the Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019	Annual

Organisation	Monitoring and reporting framework	Purpose of the framework	Frequency of reporting
NSW Mental Health Commission	Living Well: A Strategic Plan for Mental Health in NSW in 2014-2024 (2014, active)	To report on progress against the Living Well strategic plan for mental health in NSW, 2014-2024	Annual
Western Australia Mental Health Commission	Better Choices Better Lives: Western Australian Mental Health, Alcohol and other Drug Service Plan 2015-2025 (2015, active)	To report on progress against the 'better choices, better lives 2015-2025' plan.	Annual
Commonwealth organisations			
Department of Health	National Mental Health Reports (2013, inactive)	To summarise system-level changes that have taken place in mental health since the National Mental Health Strategy in 1992	Every two – three years
Productivity Commission	Report on Government Services (2017, active)	To report on the equity, effectiveness and efficiency of government services, including mental health services	Annual
AIHW	Key Performance Indicators for Australian Public Mental Health Services (2014, active,) *Note: these are an indicator set that map to the National Mental Health Performance Framework*	To measure performance in a way that supports quality improvement activities at the level of mental health service organisations	Annual
AIHW	National Mental Health Performance Framework (NMHPF) (2005)	To facilitate a culture of continuous quality improvement in mental health service. It supports Australian and state and territory governments' commitment to improving accountability and transparency at the Mental Health Service Organisation level.	Annual

The Environmental Scan Insights Report and Stage 1 stakeholder consultation identified that the main domains currently covered in the Australian landscape are:

- **System inputs, including** funding levels, funding distribution, efficiency, workforce planning and research investment
- **Access and coordination of care**, including timeliness of access, ease of access and continuity of care
- **Quality of care**, including consumer outcomes, consumer experience of care, service quality improvement and safety
- **Consumer and carer participation in care**, including the representation of consumers and carers in the mental health workforce

- **Population prevalence of mental health and wellbeing**, including rates of mental illness and high psychological distress
- **Population prevalence of suicide and suicidality**, including self-harm and rates of attempted and completed suicide
- **Seclusion and restraint**, including seclusion, involuntary treatment and restraint
- **Awareness and stigma**, including stigmatising attitudes and community awareness
- **Prevention**, mental health and suicide prevention activities
- **Physical health**, including life expectancy, physical health conditions, smoking and drug and alcohol abuse
- **Quality of life**, including social connectedness, access to suitable housing, economic participation and self-reported meaning in life.