National Mental Health Commission submission to the Productivity Commission 2019 Draft Report on Mental Health

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Introduction

The National Mental Health Commission (NMHC) welcomes the release of the Productivity Commission's 2019 Draft Report into Mental Health (Draft Report) and the opportunity to provide further comment. Broadly, the NMHC supports the recommendations in the Draft Report. This submission seeks to provide the Productivity Commission with additional information and perspectives to enhance and strengthen the recommendations in the final report.

The Draft Report aligns well to recommendations in the NMHC's first submission to the Productivity Commission inquiry and the NMHC *Monitoring mental health and suicide prevention reform: National Report 2019* (National Report 2019).[1,2] In particular, the approach taken by the Productivity Commission reflects recommendations by the NMHC for a cross-portfolio and whole-of-government approach to mental health, to prioritise investment in early intervention and recovery, and to clarify funding arrangements for mental health services.

Since it was established, the NMHC has had a strategic priority to put mental health and wellbeing on the economic agenda to better support every Australian to live a contributing life. Viewing mental health through a productivity lens highlights the benefits of preventing mental illness and promoting mental health and wellbeing as desirable outcomes. This outlook recognises the productivity gains from increasing participation, promoting recovery-oriented approaches, and investing in properly evaluated mental health services to achieve wellbeing for all Australians. The Draft Report is a positive step towards demonstrating the value of good mental health to people, families, their community, and the Australian population and highlights the importance of pursuing these outcomes through improved public policy and necessary systemic changes. The NMHC looks forward to working with the Productivity Commission to achieve this outcome.

The basis of the Draft Report and the focus of the NMHC is, and has been, that supporting the mental health, wellbeing, and resilience of Australian communities is crucial. The current bushfire crisis highlights the consequences when mental wellbeing is compromised. In the current situation this is due to the impact of significant natural disaster, however it can (and does) also result from challenges within the current policy and system regimes. These impacts include the significant economic cost across portfolios (including housing, employment, and health).

Submission outline

This submission responds to the Draft Report and offers further information as requested by the Productivity Commission. Section 1 identifies additional issues for consideration and introduces *Vision 2030: Blueprint for mental health and suicide prevention* (Vision 2030). The work the NMHC is undertaking on Vision 2030 and the accompanying roadmap to frame a reformed mental health and suicide prevention system is highly relevant to the Draft Report and its recommendations. Section 2 responds to the key reform areas covered in the Draft Report and relevant draft recommendations. Section 3 responds to specific recommendations for the NMHC, including expanding the role of the NMHC to include the national monitoring, evaluation, and reporting of mental health and suicide prevention programs and activities, and becoming a statutory authority to best enable it to expand into that additional role.

Section 1: Vision 2030 and additional issues for consideration

Vision 2030: Blueprint for mental health and suicide prevention

The Productivity Commission inquiry into mental health has been described as a 'once in a generation' opportunity for mental health reform.[3] The Australian population, those working in the mental health sector, and consumers and carers in particular, hold expectations of major transformational change to address the known deficits in the current system.

The NMHC encourages the Productivity Commission to articulate in the final report how the recommendations translate into improved outcomes. A clear description of the end goal of the recommended reforms allows for articulation of the economic, health and social benefits for individuals, families, and the Australian population, to be appreciated and to become the measure of effectiveness for future reform actions.

In recognition of the need for an overarching vision for the mental health and wellbeing of all Australians, the Government requested the NMHC to undertake Vision 2030, which was delivered to the Minister of Health in December 2019. Work has now commenced on the roadmap components. Vision 2030 provides a strategic and outcome-orientated lens through which to view the Productivity Commission's recommendations in the Final Report.

In developing Vision 2030, the NMHC focused on hearing and incorporating the aspirations, expectations and needs of people and their communities. During 2019, the NMHC's Connections project[4] conducted public meetings and stakeholder consultations to identify key themes and consensus about the barriers experienced, community needs and opportunities to improve the mental health and suicide prevention system. These themes were used by the NMHC to inform the development of *Vision 2030: Blueprint for Mental Health and Suicide Prevention*.

Vision 2030 requires two fundamental systemic changes:

- Shifting from a mental health 'alone' approach to a wellbeing approach.
- Formulation of a balanced community based approach across the mental health and suicide prevention system.

The shift from a mental health 'alone' approach to a wellbeing approach, necessitates establishing connections with the physical health care system and social determinants including housing, education, employment. This shift to social and emotional wellbeing recognises the interconnect between mental health and whole of life experience. It also reflects that it is not possible to separate, in a treatment and care and support sense, our physical health and mental health. They are two integral components of a single person. This is highlighted by the significantly lower physical health outcomes for people with mental illness. Nor can we separate the physical and mental health from the person's welfare wellbeing or social health which relate to the person's connections, housing, employment and other needs.

The formulation of a balanced community-based approach across the mental health and suicide prevention system creates a cohesive, community-based care sector, which acknowledges the contexts and needs of Australia's diverse communities and the individuals within them. Balanced community-based care is not about one type of care or service, but about the way that we deliver all aspects of prevention, assessment, treatment and recovery. There is growing international consensus that mental health services should be placed in the centre of their communities, closely linked or co-located where possible with primary health care and functionally integrated with hospital-based services. To date there has been a lack of any consistent policy framework, standards

or outcomes for the community care system and this void has been filled with disconnected programs and services funded by either the Australian Government or the state and territory governments. The Vision 2030 approach creates a cohesive system into which programs and services can be incorporated to meet needs identified by the particular community.

The NMHC has commenced work on the roadmap for Vision 2030, which will examine in detail what is required from a policy, system design, service design and outcomes, funding mechanisms, and workforce perspective. This roadmap work is grouped into the five categories of governance structures, performance enablers, system components of care, delivery mechanisms, and outcomes.

For Vision 2030 to be delivered to the Australian population, a unified system that takes a whole-of-community, whole-of-life and person-centred approach to mental health and wellbeing is required. This means an easily navigated, coordinated and balanced community-based system that allows for early intervention to meet each individual's needs, prevent escalating concerns, and enhance wellbeing.

The NMHC would welcome the opportunity to work closely with the Productivity Commission as the NMHC continues to develop the roadmap to identify touchpoints and intersections with the recommendations to be included in the Final Report.

Recommendation 1. The Productivity Commission consider *Vision 2030: Blueprint for Mental Health and Suicide Prevention* and how it may be relevant to the Final Report.

Additional issues for consideration in the Final Report

Broader consideration of the role of recovery

The Draft Report should more fully address the importance of promoting recovery, and the role of individuals, families, and communities in mental health system reform and improving program delivery and practice. It is important that the mental health system recognise that people using the system also require access to rehabilitation and recovery-based services outside of hospital and treatment services. Recovery in the context of mental health means different things to different people. Core concepts in recovery include self-directed, individualised and person-centred, strengths-based, and non-linear care. Individuals can express these concepts differently therefore recovery needs to be seen as a journey rather than an outcome[5]. The 'recovery model' is an approach that emphasises resilience and control over life's challenges[6]. It aims to help people with mental health issues move forward, set new goals, help individual's gain and/or regain purpose in life, and take part in relationships and activities that are meaningful.

People have dynamic (acute, episodic, chronic) experiences of mental illness, rather than the linear approach to mental illness which appears to have been adopted for the Draft Report—to prevent people becoming mentally ill and provide better treatment if they do become mentally ill. Recovery-based approaches recognise that not everyone will follow this path and incorporates self-management of mental health within individuals, families as carers, and communities as social support, that will more effectively address the needs of people experiencing mental illness on a continuing basis.

The NMHC supports the Draft Report's focus on improving prevention and early intervention to achieve better outcomes. Receiving earlier treatment is a key component in reducing severity and impact of illness. However, this is a clinically-centred approach that uses the individual's pathology as the primary measure of recovery. This approach does not account for the healing that can occur from the multiple social and relational interventions in a person's life outside of a clinical setting.

From a recovery perspective, the Contributing Life Framework is a useful foundation for outcome measurement. However, it is important to note that a person's recovery journey to living a contributing life is often not limited to prevention, intervention, or treatment activities provided through a clinical model.

Recovery orientated practice supports mental health service providers to consider social determinants and social interventions within a treatment plan. However, in order to sustainably embed recovery orientated practice into the mental health system, it is important that service mapping frameworks and service planning frameworks include recovery orientated services.

Recommendation 2. The Productivity Commission's Final Report include additional content incorporating the full range of principles comprising recovery to better address the ongoing needs of those experiencing poor mental health.

Recommendation 3. The Productivity Commission's Final Report make a recommendation to prioritise research on recovery to consolidate the evidence-base for recovery orientated practice, based on, and with, critical contribution from those with a lived experience.

Recommendation 4. The Productivity Commission's Final Report should include a more detailed and stronger focus on building long-term system improvements that are based on wellness, recovery and self-management of mental health for individuals, families and communities.

Recommendation 5. The Productivity Commission's Final Report make a recommendation to expand the scope of mental health service mapping frameworks and service planning frameworks to include recovery orientated services.

Expansion of the definition of community and community services and the need to include a community based care policy and funding framework

The Productivity Commission calls for major system reform in the Draft Report, with the focus of reform predominately on the governance and funding elements of the existing health system. It is important to also consider how non-health systems provide or supplement mental health services.

In relation to community services, which form part of the mental health services, the Draft Report offers some discussion around what community services are required, and how they should operate to link and complement the existing health structures, but this examination and discussion needs to be extended.

The Productivity Commission notes the need for community services, using terms such as services in the community, community-based services, community treatment services, and community support services, to describe a community-based approach to service delivery. One of the key components of Vision 2030 is the need to both define and implement a community-based care system into the overall mental health and suicide prevention system. This will provide the policy and funding framework to accommodate specific services. In relation to those services (as distinct from system), a clear and consistent definition of community services is important, particularly in relation to how the Productivity Commission defines service types in their proposed funding models.

In addition to distinguishing between community-based care system (within mental health) and community services, there is also a need to distinguish between community services and community, including different roles in relation to retaining and reclaiming a contributing life. Recognising the role of community aligns with the NMHC's Contributing Life Framework*,* where an individual is supported to live a contributing life across health and other domains. A contributing life

is one where an individual is thriving not just surviving; receives effective support, care and treatment; has something meaningful to do, something to look forward to; has connections with family, friends, culture and community; and is feeling safe, stable and secure. The NMHC believes the Final Report should include specific reference to the role of the community in the recovery and wellbeing of individuals, and how to ensure communities are supported to offer activities that enhance social cohesion and encourage individuals to connect.

The greatest benefit comes from the interaction between these three different but aligned components. Where the mental health system has a clear policy and funding framework for services; where services are provided in the community, by the community, to meet community needs; and where the community is supported to meaningfully engage with individuals and build social connectedness. Community services are only as effective as the supportive communities within which they exist and they must have an appropriate policy and funding framework in which to operate.

Recommendation 6. In addition to considering the necessity of a community-based care policy and funding framework within the mental health system (as referenced in Vision 2030), the Productivity Commission's Final Report include a definition of community services and recommendations that strengthen the dual and aligned roles of community and community services.

Health-centric approach to addressing social determinants

The Draft Report adopts a health-centric approach to addressing social determinants. Other portfolios, such as housing, employment, and justice, are included only from the perspective of how they supplement the health care provided to people experiencing mental illness. The report would benefit from including more detailed commentary on how reforms and program improvements in these and other social determinant portfolios, are likely to reduce demand for health services for those with a mental illness.

While the draft recommendations address some social determinants, they do not have sufficient depth and reach to adequately address all the underlying issues that may affect a person's and a population's mental health and wellbeing. These issues include trauma and abuse, poverty, migration experiences, and loss of conventional social connections (loneliness and social isolation). In addition, factors such as substance misuse, family and domestic violence, gambling and addictions warrant more attention.

Recommendation 7. To enable long-term shift in mental health outcomes in Australia, the Productivity Commission's Final Report recommend that the underlying factors of mental illness are routinely addressed in prevention, treatment and support policy and programs across whole-of-government activities.

Greater consideration of lifespan and diversity

A people-oriented system must consider all affected population groups and cohorts. The Draft Report raises the issue of discrimination and increased risk for mental illness for diverse groups, including LGBTIQ and culturally and linguistically diverse people. However, the draft recommendations do not directly address the unique considerations of diverse groups. Similarly, the Draft Report is predominantly adult-centric, with limited discussion or recommendations for reform that would meet the unique needs of children and older adults.

Diverse people

The NMHC notes the limited inclusion in the Draft Report's narrative and recommendations about diversity groups such as LGBTIQ and culturally and linguistically diverse consumers and carers. The NMHC believes it is important that the final report consider in more depth and detail the availability of culturally appropriate services, cultural barriers to services, and awareness of culturally appropriate services to inform a mental health system that responds to the needs of all Australians.

Children
The rapid pace of neurodevelopment during childhood affords key windows for early intervention and prevention. As a result, it is not appropriate to expect children to progress linearly through stepped care for mental health as they might reasonably do for physical health. More appropriate is a mental health system where access to child expertise is available on entry regardless of the level of risk factors or symptoms, so that a child does not have to progress through multiple steps to see a child specialist. This approach would enhance early intervention and minimise the need for multiple assessments and referrals before children receive appropriate care, leading to better outcomes. The National Children's Mental Health and Wellbeing Strategy (CMHWS) led by the NMHC will be exploring options for a more appropriate model of care for children, including the role of parents and wider family systems. For more information on the CMHWS, see PART IV in this section.

Older adults
The NMHC acknowledges the work of the Royal Commission into Aged Care Quality and Safety (Royal Commission). The NMHC would welcome inclusion and discussion about the ageing population in the Productivity Commission's Final Report, particularly given that this is a growing population. There is no nationally consistent system for the delivery of mental health services to older people, especially those living in Residential Aged Care Facilities. The quality and accessibility of services vary from place to place, and rural and remote locations tend to be less well served. As stated in the NMHC submission to the Royal Commission, the Australian Government needs to make a clear policy commitment to a coordinated national approach in the aged care and mental health systems to address what the role is of each system component to meet the mental health needs of older people.[7]

Recommendation 8. The Productivity Commission's Final Report address the specific needs of populations such as children, older people, and diverse populations in any model of care presented in the final report.

Recommendation 9. The Productivity Commission's Final Report include a recommendation on the Australian Government's role in a policy commitment to a coordinated national approach to the mental health care of older people.

System capacity and capability

Central to the Productivity Commission's inquiry into mental health is ensuring that Australians' mental health and wellbeing is supported by an effective and efficient system that is adaptive and responsive to current and future demands. The NMHC articulates this through Vision 2030 as a mental health and wellbeing system where needs-matched support is available to every Australian regardless of location. As such, the NMHC believes that system reform needs to include consideration of the capacity and capability of the system to respond to future changes to service demand.

Significant reform includes moving to a cross-portfolio approach to mental health that focuses on wellbeing and reducing stigma and discrimination as barriers to help seeking and entry. As success in these areas are realised, the increased service demand on the mental health and suicide prevention

system should be estimated by the Productivity Commission. Providing socially inclusive services within other portfolios will require an appropriate workforce response. Furthermore reducing stigma and discrimination, and providing a recovery-orientated and wellbeing focused model of services, is likely to increase the demand for mental health services. This increase in demand will need a system, which has an appropriately trained and scaled mental health workforce and which also considers the modalities of service delivery, spanning steps from prevention to treatment and recovery. The NMHC refers to this increase in use of the system as being 'organic growth'.

In addition, as highlighted by the current bushfire crisis, the system will also need to cope with sudden increases in demand. The NMHC refers to this as 'surge growth'. The NMHC believes the system needs to anticipate surge growth as a result of natural disasters and other declared emergency events. In line with national disaster response planning, the focus of the mental health system capacity and capability building needs to span immediate, short-term and longer-term responses and needs. As a complete response, the system needs to have the capacity and capability to provide general prevention and preparedness initiatives for individuals and communities to build resilience before an event, as well as being able to provide localised surge capacity during response and recovery following events.

Recommendation 10. The Productivity Commission's Final Report consider how the mental health and suicide prevention system has the capacity and capability to meet and respond to future expected and unexpected demands on the system.

Natural disasters and mental health

The Council of Australian Governments (COAG) National Strategy for Disaster Resilience notes that 'natural disasters are a feature of the Australian climate and landscape and this threat will continue, not least because climate change is making weather patterns less predictable and more extreme.'[8] This strategy identifies the characteristics of disaster resilient communities as functioning well while under stress, successful adaptation, self-reliance, and social capacity. These are all characteristics that align with a national strategy for mental health and wellbeing.

The effects of acute natural disasters on mental health are well documented, but chronic natural disasters—such as the prolonged drought being experienced by communities across Australia—brings unique challenges. Further work is required to understand how significant changes in climate, natural disasters and the particular effect of long-term exposure to natural disasters and challenges affect communities. This will inform how communities can receive adequate support, especially recognising the disproportionate impact on rural communities and potentially on different population groups, including Indigenous Australians.

The NMHC notes that in the recent *Australia Talks National Survey*, Australians ranked climate change as the biggest issue affecting them personally.[9] The percentage of young people identifying the environment as an issue of national importance has nearly quadrupled since 2018, from 9% to 34%.[10]

The NMHC notes that health practitioners increasingly view climate change as a public health issue and recognise their role in identifying, reducing and managing adverse health effects of climate change.[11] The work that has commenced for developing a national strategy on climate, health and wellbeing should be considered in the broader reform directions for mental health.[12]

Section 2: System Reform Areas

PART I - The case for major reform

The community expectation and economic need for major reform is clear and the NMHC supports the Productivity Commission's goal to create a people-oriented mental health system that prioritises prevention and early intervention, and the elimination of service gaps through efficient and effective use of taxpayer funds. The draft recommendations to improve prevention and early intervention address service gaps and create meaningful gateways. Pathways proposed by the Productivity Commission are one way of achieving this goal.

Cross-portfolio and whole-of-government

The NMHC has previously recommended a single central government agency to coordinate and oversee cross-portfolio and whole-of-government approach to mental health policy.[1,2] The NMHC would welcome the Productivity Commission considering this or alternative methods to enable a whole-of-government approach to mental health and suicide prevention. It is essential to adequately address the non-health portfolio and social determinants of mental health through a Contributing Life Framework, and to ensure mental health promotion is effective across the government portfolios, including social policy and services, employment, education, housing and justice. Alongside this work, it is also necessary to ensure that any new government policy and program be assessed for their potential impact on the mental health and wellbeing of Australians. There is an opportunity in the Productivity Commission's Final Report for these issues to be more broadly canvassed to achieve this goal.

Key strategies and mechanisms continue to sit within the Australian Government health portfolio. For example, Draft Recommendation 22.2 tasks the COAG Health Council with leading the development of a new National Mental Health Strategy. This strategy must drive reform across all relevant portfolios and levels of governments. It is essential there are formal mechanisms to enable joint ownership and accountability between portfolios and governments and the NMHC would welcome the view of the Productivity Commission in this regard.

Recommendation 11. The Productivity Commission's Final Report address the options as to how to coordinate a cross-portfolio and whole-of-government approach to mental health and the mechanisms that will enable a such an approach to mental health policy and provide strategic oversight to investment.

Change management

Major mental health reform will impact on service delivery from both a providers' perspective and how consumers and carers' experience services. Approaches to minimising any potential disruption for people involved in the system, in particular consumers and carers, will be crucial. The ongoing communication with, and involvement of stakeholders during the implementation of recommendations is critical to their success. It is important that the final report include further detail on how system level reform will be managed, and how individual recommendations will be implemented with authentic engagement with consumers and carers, professional bodies, and service providers. This needs to include strategic level risk assessments on the potential for unintended consequences through poorly executed change management detailed in the final report. Furthermore, for any change in funding arrangements, the implementation authority needs to ensure service continuity and avoid creating new gaps in services, as key priorities.

Recommendation 12. The Productivity Commission's Final Report include detail on stakeholder engagement during the implementation of reforms.

Recommendation 13. The Productivity Commission's Final Report include a recommendation to ensure continuity of service for people affected by new or changed funding arrangements.

Out-of-Pocket costs

The Draft Report seeks information on the out-of-pocket costs of mental health care. The NMHC recognises the out-of-pocket costs of mental health care for consumers and carers in Australia are significant, and continue to be a barrier to help seeking and care.

Social Science Research Solutions conducted the Commonwealth Fund International Health survey in 2013. This survey focused on household out-of-pocket expenditure on the direct costs of health care. Analysis of Australian data showed that over 40% of people with depression, anxiety and other mental health conditions stated they did not seek healthcare treatment because of the cost.[13] Additionally, after adjusting for age, sex and education attainment, Australians with depression, anxiety and other mental health conditions had 7.7 times higher odds of not engaging in treatment than Australians with no health condition. This study highlights that individuals with mental health conditions are particularly likely to forego care, indicating a need to address potentially prohibitive costs in this area. The NMHC notes that the survey did not specifically ask respondents about over the counter medication, or aids and equipment, or travel for treatment as part of the question regarding health care expenditure – therefore figures in the study may underestimate the total amount spent by households on healthcare.

Physical health problems also need to be considered in the discussion of out-of-pocket costs of health care. The NMHC commissioned a literature review into the physical health of people living with mental illness that documented the evidence on the impact to costs of comorbidity.[14] The literature review noted that the additional costs for physical health problems for people living with mental illness has been estimated to increase the costs of healthcare by 70%.[15]

PART II - Reorientating health care services to consumers

The NMHC welcomes the emphasis in the Draft Report on reorienting mental health care services to achieve a better alignment between the service system and meeting the needs of consumers. There is an identified need to ensure people receive appropriate care that matches need and preferences for access. This includes increasing the use of low intensity treatments such as online services evaluated and assessed as effective.

MBS-rebated mental health services

Many of the recommendations for MBS-rebated mental health services are consistent with previous recommendations by the NMHC and current draft findings of the Medicare Review Taskforce Mental Health Reference Group[16]. The NMHC specifically notes and supports the recommended expansion of telehealth (or videoconferencing) in Draft Recommendation 5.7 and 7.2. This is a positive step toward increasing equitable access to services for all Australians, particularly those experiencing barriers—such as location, severe physical disabilities, mental health disorders or psychosocial stress—which prevent them from attending face-to-face services. A whole-of-government approach is needed to support the infrastructure and referral structures for expanded telehealth to be effective and efficient.

In relation to Draft Recommendation 5.4, it is important that the increase of MBS rebated sessions is not viewed as a general increase for any person experiencing a mental health illness undergoing treatment. The NMHC believes that more detailed analysis should be undertaken to ensure the evidence-based modalities of care appropriate for specific illness are the ones being delivered and rebated, and that there are outcome measures included in the assessment of the need to increase the number of sessions for a person.

In its submission to the Medicare Review Taskforce, the NMHC encouraged consideration of how to measure and monitor consumers' outcomes as a result of treatments subsidised through the MBS. This includes a focus on the treatment modalities used for different diagnoses and in different circumstances and the match between the consumer's diagnosis and circumstance and the skills and expertise of the treating professional. More detailed information about services funded through the program is needed to enhance accountability for the (at least) $800 million spent each year to support mental health through the MBS. This information could also deliver greater insight into the effectiveness of services subsidised under the MBS and into where MBS might be a more (or less) appropriate funding vehicle for enabling access to different types of mental health services.

Just as the MBS is an important component of the broader mental health system, so too should work to develop its evidence base be integrated into measurement efforts across the system. The NMHC suggests an inclusive process be undertaken, involving practitioners, experts in mental health outcomes data and processes, and consumer and carer representatives.

Recommendation 14. The Productivity Commission's Final Report include a recommendation that work to develop the MBS evidence-base include specific outcomes that are integrated into measurement efforts across the system; using a co-design process involving all relevant stakeholders.

National Mental Health Workforce Strategy

The NMHC supports Draft Recommendation 11.1 on the National Mental Health Workforce Strategy, but notes that work on the Strategy (announced by the Australian Government in December 2018) is in the early stages. A collaborative approach to developing the Strategy is crucial to ensure it addresses the needs of the growing peer workforce and community mental health sector, as well as appropriately considering the contributions of carers in supplementing the care being provided. Involving states and territories will also ensure a comprehensive plan that addresses future needs of the whole workforce, workforce redesign and modelling of what the future mental health workforce should look like. It would be beneficial for the Strategy to be released with an implementation plan; however, the development of the implementation plan should not delay the release of the Strategy.

Recommendation 15. The Productivity Commission's Final Report include a recommendation for the Australian Government to produce an implementation plan in support of the National Mental Health Workforce Strategy.

Mental health peer workforce

The NMHC supports Draft Recommendation 11.4 on strengthening the peer workforce. The report and recommendation will help to inform ongoing work on the Peer Workforce Development Guidelines project led by the NMHC. The Steering Committee for the Peer Workforce Development Guidelines project endorse the following views.

Promoting the value of peer work
The peer workforce is growing significantly, and is increasingly valued across government and the community sector for contributing to better outcomes for consumers and carers. Despite significant growth, the working conditions for the peer workforce are lagging and its growth is not consistent across jurisdictions, the state and territory mental health services, the community managed sector and the private sector. The NMHC suggests that additional content in the Productivity Commission's final report on the value and contributions of the peer workforce would underline the important role of peer workers, both in supporting person-centered care and in the integral roles peers have in care delivery. The Productivity Commission's Draft Report proposes further demonstration on the ground that such benefits of peer workforce are real (such as through more trials and pilots). The NMHC recommends that the Final Report should go further by prioritising the research needed to establish and consolidate the evidence base on the value of peer work. Peer workers also need to be involved in policy and service design.

Recommendation 16. The Productivity Commission's Final Report include additional content on the value and contributions of the peer workforce.

Recommendation 17. The Productivity Commission's Final Report include a recommendation for research to be conducted as a priority to consolidate the evidence-base for the peer workforce.

Draft short-term recommendations for mental health peer workforce
The NMHC and the Peer Workforce Development Guidelines Steering Committee will consider how work standards for particular areas of practice can support the Guidelines. In September 2019, the NMHC published findings of a feasibility study conducted by the Private Mental Health Consumer Carer Network (recently renamed Lived Experience Australia) into the establishment of a member-based organisation for the peer workforce.[17] The NMHC will provide further advice to the Australian Government on the steps involved for establishing and funding this organisation.

Draft medium-term recommendations for mental health peer workforce
Workplace cultures, negative attitudes in health services, and an underdeveloped system of qualifications and professional development, are consistently identified as key challenges for the peer workforce. The Peer Workforce Development Guidelines will provide additional guidance on these matters. The Guidelines are due for completion before the end of 2021, therefore the draft medium-term recommendations could, to some degree, be progressed in the short term (within the next two years).

There are potential benefits of exploring options for recognition of prior learning, both for entry to the peer workforce and for entry of peer workers to other careers in the mental health workforce. However, there is also a need to enhance professional development opportunities and career pathways within the peer workforce, such as through increasing the availability of senior and leadership roles for peer workers with the appropriate qualifications and experience. There is also potential to further support the development of peer worker roles outside traditional health care settings (such as in digital and phone-based services), and to consider career pathways involving broader lived experience roles.

PART III - Reorienting surrounding services to people

The Draft Report recognises that people living with mental illness are more likely to experience poor social, economic, and health outcomes, including homelessness, unemployment, incarceration, and premature death. Therefore, the NMHC welcomes the focus on reorienting surrounding services to people. This focus is consistent with the Contributing Life Framework, which acknowledges the social

determinants of mental health including the role of families, employment, housing, and the justice system in "thriving not just surviving". The services that people use are important, but it is also important to look at the range of services across sectors, and the availability, accessibility, and quality of those services.

It is important to note that to sustainably reform mental health approaches across governments and government portfolios, there needs to be a mental health and suicide prevention framework developed that has a clear focus on shared mental health outcomes, prioritised through incentives, underpinned by evaluation, and with the authority to hold portfolios accountable. This will be some of the areas addressed in the Vision 2030 roadmap work.

Care integration and coordination

Care integration and coordination is critical to ensuring that what will be delivered are the best results for people living with mental illness, as well as for their families and carers. The NMHC supports the Draft Recommendation 10.3 for the development of single care plans for consumers with moderate to severe mental illness who are receiving services across multiple clinical providers. The NMHC has previously noted that a shared single care plan links providers into a person-centred approach with the positive outcome of a person with a lived experience only needing to tell their story once, not many times.[18]

The core principle of a person-centred single care plan is the emphasis placed on coordination, collaboration, and inclusivity of the services to meet the individual's recovery goals. The development of a care plan needs to be driven by the consumer and co-designed with all stakeholders including the consumer; supporting consumers' decision-making is integral for the success of a single care plan. This includes supporting a consumer to identify their primary treating clinician and care coordinator, and to establish meaningful recovery goals. It is also essential to consider and consult widely with other service providers including consumer and carer bodies, and Aboriginal and Torres Strait Islander bodies. In this way , a single care plan promotes engagement with and between relevant stakeholders and ensures all providers are meeting the recovery goals of the individual, and actively managing issues around consent and privacy when sharing information between providers. A person-centred approach to care planning incorporates all aspects of a person's life including their relationships and connections to community and others.

At a system level, the design of any single care plan model also needs to be person-centred and consumer driven, and reflect the same core principles that support the success of an individual's single care plan. Without a considered co-designed approach with all relevant stakeholders, the benefits that could be realised from a single care plan model will not be achieved.

Three out of five people living with a mental illness have a co-existing long-term physical health condition. Therefore, coordinated care needs to be holistic and routinely include physical health checks, supported by the sharing of relevant physical health information between treating health practitioners and care providers, with the informed consent of the consumer.[19] This aligns with element four of the Equally Well consensus statement that promotes physical health checks as integral to the care of people living with mental illness.

Recommendation 18. The Productivity Commission's Final Report recommendations about single care plans ensure that mental health care plans are implemented based on consultation and co-design with the consumer and relevant stakeholders for that consumer; these plans should also cover physical health checks and support the appropriate and informed sharing of a consumer's physical health information.

Carers and Families

The Draft Report emphasises the need to enhance supports and carer-inclusive service delivery for carers. Best estimates have attempted to develop a replacement cost of mental health carers of $13.2 billion.[20] However, the role of the mental health carer is unique and estimates lack the inclusion of the impact on relationship stress, emotional wellbeing and carer mental health. This includes the impact on the whole of family, in addition to the identified carer. The complexity of this role, including factors such as the episodic nature of mental illness, create significant barriers in the application of current carer support services. The NMHC supports Draft Recommendation 13.1 including proposed amendments to current carer payment and allowances to increase the flexibility of criteria, taking into consideration the specific nature of the mental illness and the importance of increased flexibility for mental health carers in the workplace.

The NMHC also supports MBS changes under Draft Recommendation 13.3 and note these are consistent with previous submissions and current draft findings of the Medicare Review Taskforce Mental Health Reference Group.[16]

Housing and homelessness

The Draft Recommendations on housing and homelessness are consistent with the NMHC's Contributing Life Framework*,* and the findings of the NMHC commissioned report by the Australian Housing and Urban Research Institute, which highlight the severe mental health consequences that result from even brief periods of homelessness.[21]

Stable housing is a critical foundation in preventing mental illness and for an individual's journey to recovery. The Draft Report presents an approach founded on the national and international evidence that indicates the importance of having a stable home for an individual's ability to lead a contributing life. This evidence highlights that for people living with mental illness, getting and keeping their own home is harder to achieve compared to the general community.

The NMHC supports the prevention of homelessness as a key policy aim, and recommends the Productivity Commission explicitly address the need for policy integration. Lack of policy integration, pooled funding, and cross-sector accountability mechanisms between the housing, homelessness and mental health sectors impedes the development of integrated solutions. Changing these factors requires collaborative leadership across all levels of governments and across sectors.[21] This includes national monitoring, evaluation and reporting on the implementation of "no discharge into homelessness" policies across sectors (justice and health) in all jurisdictions.

Recommendation 19. The Productivity Commission's Final Report explicitly address the need to integrate housing and homelessness policies with mental health policies.

Justice system

There has been considerable research demonstrating the contribution the justice system has on the ability to achieve public mental health objectives, and the high prevalence of mental disorders among justice-involved populations, including those who come into contact with the police, courts, prisons, and the youth justice system. Prisons and youth detention centres are therefore critical sites for reducing health inequalities.

The NMHC welcomes the Draft Report's recognition of the intersection between mental health and the justice system and supports the recommendations to improve the interventions for people that are within the justice system. However, additional action is required to achieve parity between the

mental health support available for those in the justice system and the support available to people through the mainstream mental health system.

Mental illness and the justice system have a complicated relationship. Involvement with the justice system does not only mean people engaged in the criminal courts or who are incarcerated, but also includes people engaged with civil and family courts, police, and who are victims of crime. While most people with a mental illness, including those with major illnesses, do not commit crimes, people living with a mental illness are more likely to be involved within the justice system[22]. Additionally, if not provided appropriate mental health support, people living with a mental illness are more likely to become re-involved with the justice system. It is likely that access to earlier intervention and appropriate care would prevent involvement within the justice system. Significantly overrepresented within mental illness prevalence and within the justice system, are Aboriginal and Torres Strait Islander people. Reforms in both systems need to address the profound generational impact on individuals and communities both presently and in the future.

The NMHC recommended in the first submission to the Productivity Commission the implementation of a justice reinvestment approach to criminal justice, initially for Aboriginal and Torres Strait Islander communities, and pending the evaluation of this initiative that the approach is rolled out broadly. That submission detailed the rationale for this recommendation. The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) final report also recommended a justice reinvestment approach to redirect government funding away from the criminal justice system into local Aboriginal and Torres Strait Islander communities, to develop community-led upstream diversionary activity for Indigenous young people. Noting concerns that there is insufficient evidence to support justice reinvestment, the NMHC urges the Productivity Commission to make a recommendation to build the evidence base for early intervention and prevention initiatives such as justice reinvestment and health justice partnerships, as reform areas of greatest potential.

Draft Recommendation 16.1 which focuses on support for police, should also consider the mental health of first responders, including police and other emergency services, in the development of strategies to reduce the risk of mental illness and promote mental resilience amongst this workforce.[23]

The NMHC has commissioned work to audit government strategies, policies and plans and report on gaps in the justice system. This will include some identification and analysis of transition supports and may include commentary on the appropriate treatment of forensic patients. The final report is due in the first quarter of 2020 and the NMHC will share the findings, particularly as they relate to information requests 16.1 and 16.2, at that time.

Recommendation 20. The Productivity Commission's Final Report include a recommendation to build the evidence base for early intervention and prevention initiatives such as justice reinvestment and health justice partnerships.

Psychosocial support and the National Disability Insurance Scheme

The introduction of the National Disability Insurance Scheme (NDIS) has changed the way in which psychosocial support services in Australia are funded, delivered and accessed. Many people with severe and complex mental illness require psychosocial support, including but not limited to NDIS participants with a psychosocial disability. The NMHC agrees with the Productivity Commission's position that psychosocial support must be made available to all those who need it regardless of whether they access the NDIS.

The NMHC supports Draft Recommendation 12.1 for all governments to extend the contract length for psychosocial supports. The Australian Government has extended the three year funding cycles for Primary Health Networks (PHNs) to include an additional 12 months funding on an annual basis based on meeting performance criteria. However, as noted in the NMHC's National Report 2019, there is no requirement for the PHNs to enter into longer term contracts with services providers. It is important that the Australian Government encourage PHNs to extend the contract length for existing psychosocial support services who can demonstrate efficacy and suitability in providing services in their region, and where feasible, enter into longer-term contracts when commissioning services with new providers.

There is also a critical need to address how governments will meet the service needs of the significant proportion of people with psychosocial disability who do not apply for the NDIS or who are found ineligible for the scheme. The NMHC supports Draft Recommendation 12.2 to change requirements for continued access to psychosocial support so that anyone who requires it is able to access it, including former participants of Australian Government-funded psychosocial supports. A national evaluation of barriers to applying for the NDIS will provide insight into what is required at a national level to support those that do not apply for the NDIS, or who are not successful in gaining access. Results of any evaluation conducted on people applying for the NDIS should be publicly available.

The NMHC supports Draft Recommendation 12.3 that the NDIA continue to improve its approach to people with psychosocial disability by completing evaluations of the psychosocial disability stream trials, and incorporating lessons learned into the stream. In order to understand what does and does not work, it is important that the NDIA publish information about evaluation outcomes of trials and pilots relating to people with psychosocial disability.

Recommendation 21. The Productivity Commission's Final Report include a recommendation for the Australian Government to encourage Primary Health Networks to extend the contract length for existing psychosocial support services who can demonstrate efficacy and suitability in providing services in their region, and where feasible, enter into longer-term contracts when commissioning services with new providers.

Recommendation 22. The Productivity Commission's Final Report include a recommendation that the Australian Government and state and territory governments ensure that in the long-term, people who apply, or who are found ineligible, for the NDIS have access to adequate psychosocial support services.

Recommendation 23. The Productivity Commission's Final Report include a recommendation for a national evaluation that explores barriers to applying for the NDIS, as well as the availability and access to psychosocial support for people who do not apply or who are ineligible for the NDIS.

PART IV - Early Intervention and Prevention

The Draft Report recognises the significance of early intervention and prevention to achieving positive mental health outcomes and maintaining wellbeing. The broad approach of lifespan, illness, and episode to early intervention used by the Productivity Commission is particularly welcomed. However, as stated in Section 1 of this submission, the NMHC believes that the Final Report should reconsider the reform approach to children's services.

Early Childhood

The importance of early intervention and prevention for the mental health and wellbeing of children is well established, with more than half of all mental illness beginning before age 14.[24] Supporting mental health and wellbeing in children, and intervening early when individuals are at risk reduces distress, disadvantage and disability over the lifetime. There is an increasing awareness of the critical window between conception and a child's second birthday ('the first thousand days') both for physical and mental health outcomes into adulthood.[25]

National Children's Mental Health and Wellbeing Strategy

The NMHC supports the inclusion of early intervention and prevention as a priority reform area by the Productivity Commission, and is pleased to be leading the development of the National Children's Mental Health and Wellbeing Strategy (CMHWS). The CMHWS was announced in August 2019, as part of the Australian Government's Long-Term National Health Plan. The CMHWS focusses on children from 0 – 12 years and is intended to provide a framework for preventing mental illness and reducing its impact on children, families and the community and to guide and inform the Government's investment in this domain.

Recommendation 24. The Productivity Commission's Final Report recommend the National Children's Mental Health and Wellbeing Strategy be used to guide future funding, program and policy decisions.

Perinatal mental illness

The NMHC supports Draft Recommendation 17.1 for universal screening for perinatal mental illness, and notes the related commentary identifies the need for appropriate and available services to be available for referral when screening has a positive result. However, there would be utility in providing explicit referral pathways and identification of services at the point of introduction of screening.

The NMHC further notes that expansion of the Perinatal National Minimum Data Set may not be an effective tool for identification of referrals and outcomes, given that the current definition of the perinatal period in this data collection commences at 20 completed weeks (140 days) of gestation and ends 28 completed days after birth[26]. This appears to exclude the onset of maternal (parental) mental illness beyond 28 days post-partum and does not provide for long-term follow up of referrals and treatment outcomes beyond this period.

Recommendation 25. The Productivity Commission's Final Report strengthen the recommendation regarding universal perinatal screening and perinatal national minimum dataset to ensure it includes the need for explicit referral pathways and identified services, and screening is conducted at optimal timing.

Pre-school aged children

The Draft Report highlights the opportunity to improve the engagement of pre-school aged children and their families in early intervention and prevention in relation to mental health. However, expansion (or re-instatement) of early childhood checks must be underpinned by availability of specialised child mental health services supporting community and primary health care with consultation and advice. This also applies to the upskilling of early childhood educators in the social and emotional wellbeing of children, as part of professional development. Such training needs to occur in parallel with access to specialist child mental health services for support with identification,

management and referral pathways where necessary and for the introduction of social and emotional wellbeing leaders in schools.

Recommendation 26. The Productivity Commission's Final Report strengthen the recommendations around early childhood checks and early childhood educators to ensure that they are underpinned by specialised child mental health services supporting community and primary health care.

Schools

Given the critical role the education system plays in supporting the mental health and wellbeing of children and young people, the NMHC supports the recommendation for educational reforms such as the introduction of School Wellbeing Leaders. The education system provides the ideal environment to provide and support early intervention and universal prevention programs to all school-aged children and young people, and a dedicated role would support delivery of inclusive programs and activities that specifically address the needs of the school's population. For example, the school based interventions to prevent bullying, anxiety, and depression, modelled as part of the NMHC project on the economics of investing in mental health prevention.[27]

To enable the successful delivery of this reform, the Productivity Commission need to consider the following:

- School wellbeing leaders must preferably be experienced with specialist expertise in child mental health and wellbeing. Where specialist expertise in child mental health is lacking, school wellbeing leaders should be trained in child social and emotional development and mental health at a minimum.
- School wellbeing leaders should be appropriately supported, with direct lines to specialist child mental health services to provide advice, recommendations and treatment if required.
- The position of school wellbeing leader should not replace existing mental health and wellbeing supports within schools, but rather oversee and coordinate these supports (such as school psychologist and counsellors).
- School wellbeing leaders should perform a capacity building function and facilitate mental health and wellbeing awareness workshops or training for teachers, parents and students
- The program needs to be integrated with other local social and psychosocial support services, be flexible enough to accommodate local and regional differences, and be delivered using a family inclusive approach.

A key question for the Productivity Commission to consider is whether these positions would be funded by the education or health portfolio. A whole-of-government approach to mental health requires consideration of issues of funding and collaboration where outcomes from one portfolio drives outcomes in another portfolio, such as the intersect of mental health outcomes driving education outcomes and how the two sectors combine.

Social Inclusion

The NMHC welcomes the emphasis in the Draft Report on the benefit of social participation and inclusion in preventing mental illness and supporting recovery and wellbeing. The Draft Report acknowledges the role that socioeconomic disadvantage, stigma and discrimination play in social exclusion and mental illness, with recommendations for improvement covered in the specific sections such as housing, employment, justice, healthcare services and psychosocial supports. The NMHC believes that this approach can be further strengthened to ensure that the needs of vulnerable consumers' are understood and met when accessing services across government and

non-government sectors. The NMHC encourages the Productivity Commission to highlight the responsibility the Australian Government has in leading reform in this area by ensuring that policies and processes to improve the experience and meet the needs of vulnerable consumers are developed across all of government services.

The NMHC supports Draft Recommendation 20.2 concerning improvements in standards and practices in the insurance sector (particularly life insurance) in relation to mental health. The results of any and all reviews, evaluations and monitoring processes related to this recommendation should be made public within a reasonable timeframe of their completion, or where possible (through ongoing monitoring) at regular intervals during the review and evaluation process.

Recommendation 27. The Productivity Commission's Final Report recommends the Australian Government reviews government service policies and processes to meet the needs and improve the experience of vulnerable consumers.

Recommendation 28. The Productivity Commission's Final Report recommends the outcomes of reviews, evaluations or monitoring relating to the improvements of standards and practices in the insurance sector be made public.

Suicide prevention

The NMHC notes that the Productivity Commission's view of the need for a whole-of-government approach to suicide prevention is consistent with the decision by COAG in December 2018 to elevate suicide to a whole-of-government issue and a COAG priority.

At a population level, there is good evidence to indicate improved mental health and wellbeing in our communities can contribute to a reduction in suicidality and completed suicides. However, the NMHC acknowledges that further work is required to adequately address how investments in prevention and wellbeing activities will contribute to a lasting reduction on suicide rates and levels of suicide behaviour in Australia. The linkage between major mental health reform and more effective suicide prevention needs to be explored and articulated. In particular, attention needs to be given to the important contribution that reducing psychological distress and the prevalence of mental illness, and increasing mental resilience, will have on suicide prevention.

The NMHC supports the specific recommendations targeting reducing fragmentation and confusion around roles and responsibilities in suicide prevention, and renewing the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and associated implementation plan, but notes that any plan specific to the needs of Aboriginal and Torres Strait Islander peoples also aligns, as much as possible, with other national suicide prevention plans and initiatives. The NMHC also supports the establishment of universal access to aftercare in line with evidence-based practices for anyone who presents to a hospital, GP or other government service following a suicide attempt. However, by limiting access to this care to people who have already attempted suicide, people who present to services with suicidal ideation in the absence of an attempt would be excluded. The definition, scope and resourcing of aftercare services should be expanded in scope based on an evidence-based approach and best practice.

Recommendation 29. The Productivity Commission's Final Report strengthen the recommendation regarding availability of aftercare services to include people experiencing suicidal ideation in the absence of a suicide attempt, incorporating an evidence-based approach and best practice.

Mentally Healthy Workplaces

The NMHC supports the draft recommendations and agrees that addressing underperformance due to work strain, anxiety and work-related stress will yield significant productivity gains. In the discussion of work-place mental health, the NMHC suggests the Productivity Commission strengthens the wording on the responsibility of workplaces to support employees irrespective of the cause of their mental health conditions. The NMHC's National Workplace Initiative will be addressing several of the issues identified in the Draft Report, including:

- supporting employers to address work outcomes for those with a work-related mental health condition
- identifying the workplace initiatives and programs that are likely to reduce the risks of workplace psychological injury for various workplaces according to size, industry and occupation
- working with Employee Assistance Program providers to improve the quality of services by strengthening the evidence on outcomes and trends, and to support improved employer understanding of EA Programs
- monitoring and collecting evidence from employer interventions to create mentally healthy workplaces.

The National Workplace Initiative will enhance the current state and industry-level initiatives underway by improving employers' access to contemporary research findings and by addressing employers' acknowledged need for clear and practical implementation assistance. The National Workplace Initiative is looking at policy and systems rather than regulation and is guided by a broad stakeholder body (the Mentally Healthy Workplace Alliance). It is looking to address the needs of a broad range of employers from sole-traders, small to medium enterprises, larger organisations, government and non-government organisations.

Through the National Workplace Initiative, the NMHC intends to strengthen the national conversation about the likely impact of future workforce trends and suggest the Productivity Commission's final report supports this approach.

Recommendation 30. The Productivity Commission's Final Report recommend the National Workplace Initiative be used to guide and inform future funding, program and policy decisions.

PART V - Pulling together the reforms

The Draft Report describes the complex landscape of policy documents, funding and service responsibilities that exist at a macro level in the mental health and suicide prevention system, and highlights the important role of leadership in the successful implementation of reforms. The Draft Report places the COAG Health Council as central to providing the national leadership for whole-of-government and cross-portfolio reforms predominantly through the new National Mental Health Strategy and the National Mental Health and Suicide Prevention Agreement. These seek to bring a systemic perspective to mental health and suicide prevention by clearly defining the areas of policy and funding responsibility, ensuring transparent evaluation occurs, and shared outcomes and targets are applied. The NMHC supports these areas of reform and acknowledges the recommendations in the Draft Report are one way of achieving this intent.

Governance, responsibilities and consumer participation

The NMHC supports the Draft Report's approach to strengthening the cross-portfolio and whole-of-government efforts beyond the current health focus and governance structures. The NMHC

appreciates the intent of the proposed National Mental Health Strategy and supporting National Mental Health and Suicide Prevention Agreement to meet these functions. The Final Report would benefit from providing greater clarity around how these new policy documents will overcome limitations of the current policy documents and governance structures, and more detail on the mechanisms that enable the whole-of-government approach.

The Draft Report recognises the need to strengthen the involvement of consumers and carers in all aspects of system planning but provides limited guidance on how this will be achieved. As the Victorian Royal Commission noted, a redesigned mental health system can only be truly responsive if the people who turn to it for help—those with the most at stake—are involved in its creation.[28] The final report needs to be clear on how consumers and carers are going to be directly involved in all aspects of system planning, design, monitoring and evaluation.

The NMHC supports an organisational structure/s for the collective voices of consumers and carers to be supported by all governments to ensure authentic collaboration. However, the NMHC recognises that there is a contested view across the sector as to whether a structural peak body is for consumers and/or carers.

Recommendation 31. The Productivity Commission's Final Report strengthen the recommendation to enhance consumer and carer involvement in all aspects of system planning, design, monitoring and evaluation, by providing detail on how this can be achieved.

Funding

The Draft Report identifies the funding complexities that exist in the current mental health and suicide prevention system, in particular for the government funded services and programs, but also compounded by the significant role played by non-government organisations in the delivery of services. The Draft Report argues that for the system to improve, the funding model needs to be simplified to a single commissioning process and/or the amount of funding provided by Governments needs increasing. The draft recommendations place greater emphasis on the former than the latter. There are significant benefits to simplifying the funding model, but increased funding should not be ignored as a means to improve outcomes.

The Draft Report provides significant evidence of the economic costs of mental illness to Australia but there is limited financial modeling to demonstrate the cost efficiencies of the reforms recommended by the Productivity Commission. An estimate of the investment required to achieve the outcomes intended through the Productivity Commission's recommendations would be welcomed. This would improve the ability to target system reform and develop a true cross-portfolio approach to the delivery of services in the mental health and suicide prevention system. Without proper economic modelling it is not possible to determine the desired or unintended impact of a non-health social policy change, such as improved access to housing, on mental health and suicide prevention outcomes. With this modelling, the positive health benefits of funding an initiative in another government portfolio can be clearly demonstrated, supporting cross-portfolio collaboration.

The Draft Report also describes funding imbalances between the Australian and state and territory governments, and presents two options for future funding—a 'rebuild' model and a 'renovate' model. The NMHC supports funding changes that allow mental health and suicide prevention services to be commissioned regionally, where local needs are better understood. However, the NMHC is hesitant to support a 'rebuild' model. In addition to creating major disruptions to existing services and structures with the potential to impact negatively on people and communities, a

‘rebuild’ model where funding is moved from the Australian Government to state and territory governments for regional commissioning has some challenges:

- It does not recognise that state and territory governments, who are traditionally responsible for commissioning and implementing tertiary care, may not be best placed to understand or commission primary care services.
- It does not provide for adequate monitoring of the return on investment of Australian Government funds.
- It creates another ‘layer’ between funders, service providers and consumers and carers.

The NMHC strongly supports regional approaches to commissioning but believes this needs to recognise and leverage the federated model of health care funding and care delivery.

Regardless of who is responsible for funding services, mechanisms must be put in place to ensure services are commissioned to meet the needs of the community, and are integrated seamlessly from the consumer and carer perspective. This means greater analysis and emphasis needs to be placed on reforming the commissioning processes to ensure decisions are strategically aligned, coordinated, and duly diligent. As a legacy of traditional and historical approaches to service delivery, the funding model is imbalanced, with greater weight given to the primary and acute care services. Future funding models need to strengthen the approach to funding services across the stepped care model, and include early intervention and community-based services. This will ensure the funding model supports not only people experiencing mental illnesses but also the prevention of mental illness and promotion of wellbeing and recovery.

Recommendation 32. The Productivity Commission’s Final Report include recommendations that ensure any new funding models can support a community needs approach and are able to fund services across the whole stepped care model.

Monitoring, evaluation, and reporting

The NMHC supports the strengthening of the evaluation of the Australian investment in the mental health and suicide prevention system in terms of efficiency and effectiveness. The NMHC monitoring, evaluation and reporting role is discussed further in Section 3 of this submission. The NMHC has long advocated for a coordinated, ongoing and expanded approach to mental health and suicide prevention data. The recommendations in the Draft Report go some way to improving the overall approach to mental health and suicide prevention data, however the report would benefit from additional advice about how economic modelling can be used to better understand how investments in mental health contribute to better outcomes.

Recommendation 33. The Productivity Commission’s Final Report includes advice on how economic modelling can be used to inform the ongoing monitoring, and reporting evaluation of the mental health and suicide prevention sector.

Section 3: Draft Recommendations for the National Mental Health Commission

The Draft Report includes a number of draft recommendations for the NMHC and requests additional information from the sector to inform these recommendations for the Final Report.

Draft Recommendations for change of role for NMHC – national evaluation role and multijurisdictional body

Draft Recommendations - 22.5 - Building a stronger evaluation culture and 25.7 - Principles for conducting program evaluations

The Draft Report has a specific recommendation to enhance the NMHC's role to independently monitor and report on the mental health and suicide prevention system, provide policy and practice advice, and act as a catalyst for improvement. This recommendation seeks to clarify and authorise the NMHC's function as an independent cross-portfolio multijurisdictional monitoring, evaluation and reporting body for government funded mental health and suicide prevention programs, and non-health programs that contribute to these outcomes.

The Draft Report includes Draft Recommendation 25.7 that ensures appropriate sector consultation occurs to develop the evaluation principles for the NMHC, before authorising these principles through the COAG Health Council.

These recommendations are framed around the COAG Health Council endorsing the NMHC to undertake a broad-ranging evaluation role, and in undertaking this additional responsibility, there is a need for the NMHC to become a statutory authority.

Becoming a statutory authority would enhance the interjurisdictional monitoring, evaluation and reporting role of the NMHC by:

- legislating the relationships and responsibilities for conducting system evaluation and improvement
- documenting independence and expert status
- increasing the ability to hold others accountable.

The NMHC considers that the coordination and oversight of a strategic whole-of-government approach to mental health should be conducted separately from the body responsible for monitoring, evaluating and reporting mental health policy outcomes.[1] It is important that the responsibility for policy delivery and coordination be separated from the responsibility to monitor, evaluate and report on policy outcomes, so that independence and integrity can be achieved for both functions. The transparent arrangement of responsibility for these functions is also important in fostering public trust in the mental health and suicide prevention system. However, just as important as achieving independence is ensuring that these functions are coordinated and complementary. It is possible to achieve this within a single organisation (that provides separate functions).

The NMHC supports the need for the sector to have both functions, (the coordination and evaluation of mental health and suicide prevention policy), to better understand the value of the investments being made in support of systemic improvement and achievement of outcomes. The NMHC acknowledges the small number of government bodies that would already have, or be reasonably able to develop, the specialist knowledge and level of independence to conduct these functions. The Draft Report reflects the level of support from within the sector for the NMHC to undertake these functions. As such, the NMHC is open to taking on the responsibility of providing these functions to the sector, and notes the benefits of becoming a statutory body to the expanded NMHC role of independently monitoring, evaluating and reporting on the mental health and suicide prevention system.

Recommendation 34. The NMHC supports the Productivity Commission's recommendations for the NMHC to independently monitor, evaluate and report on the mental health and suicide prevention system and notes the need to identify the mechanisms to support this responsibility.

System evaluation
The NMHC agrees that the mental health and suicide prevention system requires greater robustness in its evaluation culture. The NMHC also believes the drivers for this extend beyond the public funding efficiency and effectiveness outcomes as currently identified in the Draft Report and should include the drivers for cultural change outcomes that are important for all system participants, in particular consumers and carers, based around the Contributing Life Framework.

The Draft Report calls for the NMHC to lead the evaluation approach, through a consultative coordination and expert guidance function, including program level evaluations. The NMHC supports such an evaluation function and notes that it would be based on an evaluation at a systems level (which would include program evaluation as necessary to evaluate the effectiveness and efficiency of the system). System level evaluation needs to be conducted through impact evaluation methodologies that recognise contextual, environment and program contributions, rather than only applying an attribution approach to program level evaluations.

This is important when designing a system level evaluation framework. While research and program evaluations seek to control for other influences on the measured outcome, a system level evaluation has to find other ways to accommodate the complexity of the 'real world'. In the 'real world' consumers and carers access multiple programs and services, which is why outcomes cannot be directly attributed to a single program or service. Therefore, system level outcomes are derived by looking at the collective impact across programs and services. The NMHC's evaluation function needs to ensure that regional or local program evaluations are translated into continuous improvement of national policy, practices, and services. For a country as geographically spread and regionally diverse as Australia, these 'real world' variations are critical to the effective monitoring, evaluation and reporting at a national level. For governments, across all jurisdictions, there is a need for data and advice that relates clearly to the experiences and varied needs of different sub-populations and communities, within a national policy framework.

Independence
A core tenet of evaluation methodology is independence. The NMHC recommended in the first submission to the Productivity Commission that the NMHC's position in government be reviewed to strengthen independence in support of the monitoring, evaluation and reporting role. The Draft Report stated that a secondary motivation for providing statutory authority to the NMHC was to increase the level of independence, and a number of sector representatives supported this method to strengthen the independence of the NMHC.

Sequence of recommendations
The Productivity Commission's recommendation for the NMHC to have statutory authority and conduct an evaluation function is a medium term (2-5 years) outcome. The Draft Report recommends that the issue of NMHC's statutory authority and evaluation role be informed by sector consultations and COAG Health Council agreement in the short term (1-2 years). This timeframe is reasonable when considering the actions required to build the evaluation specialist capability and capacity within the NMHC, and appropriately resource and structure the NMHC in support of this focus. The medium term timeframe also supports the requirement to clearly identify and articulate the NMHC role as a statutory body and effect the legislative change required to underpin this change.

The Draft Report makes short-term recommendations for the NMHC to immediately conduct an evaluation function, such as a meta-analysis of the suicide prevention trial sites. To achieve success in these short-term evaluation recommendations, the NMHC will require mechanisms to support the interjurisdictional monitoring, evaluation and reporting role, in lieu of statutory authority. Implementing these recommendations successfully will rely on significant change management planning and support from other agencies and the sector.

Recommendation 35. The Productivity Commission's Final Report needs to make short-term recommendations that support the NMHC to immediately conduct the independent monitoring, evaluation and reporting role.

Draft Recommendation - 25.4 – Strengthened monitoring and reporting

The NMHC supports the recommendation for strengthened monitoring and reporting, and suggests this function is referred to as a monitoring, evaluation and reporting function so that the ongoing and continuous monitoring is reinforced, in addition to the periodic evaluations and the scheduled reporting.

Recommendation 36. The Productivity Commission's Final Report should refer to the NMHC role as monitoring, evaluation and reporting.

Social determinants and Contributing Life Framework
The NMHC has consistently advocated through the Contributing Life Framework for the inclusion of social determinants when monitoring and reporting on mental health, suicide prevention and wellbeing reforms and outcomes. The NMHC places consumer and carer outcomes as core to the meaningful monitoring, evaluation and reporting of the mental health and suicide prevention (inclusive of wellbeing) system. The NMHC recommended the Australian Government make the collection of experiential data a routine part of service delivery through the administration of surveys for consumers, carers, and the Living in the Community Questionnaire[2]. The NMHC Fifth Plan monitoring and reporting is informed by a consumer and carer survey, where the findings are publically available in a specific report.[29]

Outcome framework for evaluation
In 2018 the NMHC engaged the Nous Group to develop a monitoring and reporting framework for mental health and suicide prevention for 2018 to 2022 to inform NMHC's monitoring and reporting work.[30] The purpose of the framework was allow the NMHC to identify outcomes based on the Contributing Life Framework and informed by consumers and carers. The NMHC has used the monitoring and reporting framework principles to improve the approach to monitoring for the NMHC's annual National Reports, Fifth Plan reporting, and spotlight reporting.

Evaluation should be orientated to an outcome framework for mental health and wellbeing of the Australian population, and employ an outcomes mapping approach to ensure outcomes are well articulated and considered from short term program and service level outputs to the long-term population level outcomes.

The NMHC recognises there is still much to do to move the routine monitoring and reporting focus towards consumer and carer outcomes and include social determinants through a cross-portfolio remit. The NMHC is committed to working with all relevant stakeholders and sector experts in the development of a monitoring, evaluation and reporting approach focused on outcomes derived from the Contributing Life Framework, including developing an indicator set to monitor progress against these outcomes. Such a coordinated approach is critical to enabling the NMHC to monitor, evaluate

and report on the various current or planned strategies or frameworks in this space. An uncoordinated approach to monitoring, evaluation and reporting would limit the usefulness of reports to system beneficiaries including policy makers, service providers and importantly consumers and carers.

Recommendation 37. The Productivity Commission's Final Report include a stronger definition of an outcome framework and incorporates the Contributing Life Framework and the relationship of this framework to the monitoring, evaluation and reporting actions for the NMHC.

As previously stated the NMHC supports the intent of the draft recommendation for the Australian Government to establish a National Mental Health Strategy to cement cross-portfolio whole-of-government efforts and coordinate the supporting strategies into a shared outcome model. In effect, this is what is being achieved through the Vision 2030 and its roadmap. Aligned with this, the NMHC supports the draft recommendation to establish publicly reported targets for the outcomes through an appropriate methodology and via collaboration. As recommended in the NMHC's National Report 2019, the NMHC supports transparency in monitoring, evaluation and reporting methods and ensuring the outcomes are made public. This approach would increase efficiencies in the NMHC's monitoring, evaluation and reporting of the system and enhance the meaningfulness of reporting to all beneficiaries.

Recommendation 38. The Productivity Commission's Final Report notes that the evaluation framework will be co-designed with all relevant stakeholders including consumers and carers, and that reporting of outcomes are to be made public.

Data

The NMHC notes any efficiencies and improvements to monitoring and reporting is reliant on routinely collected data that is available, accessible, and consistent across jurisdictions. While the Draft Report acknowledges issues around data, the recommendations for improvement are predominantly medium to long-term, which does not support short-term improvements in monitoring, evaluation and reporting.

Recommendation 39. The Productivity Commission's Final Report considers making recommendations to ensure national data quality and consistency is improved as a priority of any national strategy or agreement.

Draft Recommendations for the NMHC to monitor, evaluate and report on specific actions

The Draft Report contains a number of recommendations which task the NMHC with monitoring, evaluating and reporting specific actions, such as the proposed National Mental Health Strategy. As a core function the NMHC currently monitors and reports on the mental health system and major reforms through the annual National Report and Fifth Plan report. The NMHC remains committed to monitoring and reporting on the mental health system and major reforms regardless of the outcome of the Draft Report recommendation for the NMHC to strengthen the monitoring and reporting role by including an evaluation function and to become a statutory authority.

The NMHC specific recommendations are listed below in the order they appear in the Draft Report,. The sequence does not reflect the significance or priority the NMHC places on the recommendation.

Draft Recommendation - 11.4 Strengthen the peer workforce

The NMHC supports the recommendation to establish a national representational / regulatory body for the peer workforce. For further discussion, see Section 2 of this submission.

Draft Recommendation - 13.3 Family-focused and carer-inclusive practice

The NMHC acknowledges the intent of the recommendation to improve outcomes for children of parents with mental illness by commissioning a trial and evaluation of the efficacy of employing dedicated staff to facilitate family-focused practice in state and territory government mental health services. The NMHC would support the design and evaluation of the trial, regardless of how the trial was funded.

It is a service wide responsibility to ensure family-focused and carer-inclusive mental health service delivery and the NMHC proposes that the Productivity Commission consider alternative ways to achieve these aims. For example, the Private Mental Health Consumer Carer Network (recently renamed Lived Experience Australia) has developed *A practical guide for working with carers of people with a mental illness* accompanied by online training, an online library, app and implementation plan, which may prove informative.[31]

Mental health and suicide prevention services should provide family-focused and carer-inclusive care as routine practice. To inform this practice the NMHC recommended in the first submission to the Productivity Commission that state and territory governments consider implementing the Mental Health Carer Experience Survey as a routine service measure, and that findings from data such as these surveys be made public.

Draft Recommendation - 17.1 Perinatal mental health

The NMHC supports the NMHC role in this recommendation. For further discussion, see Section 2 of this submission.

Draft Recommendation - 20.1 National stigma reduction strategy

The NMHC supports the intent of the recommendation for the NMHC to develop and drive the implementation of a national stigma reduction strategy that focuses on the experiences of people with mental illness that is poorly understood in the community. It is important to note that the recommendation includes some actions listed in the Fifth Plan. The NMHC Connections tour heard from individuals and communities that stigma and discrimination continue to be a significant barrier to care for those who require it. As a result, stigma reduction is identified as an essential component of care and prevention in the NMHC's Vision 2030, which focuses on three types of stigma, self, societal, and structural (discrimination), with the latter focusing not only on health professionals, but across many levels of society including; employment, visas and immigration, insurance, family court issues around custody of children, and access to housing and other social determinants.

The Fifth Plan has a Priority Area that is focused on reducing stigma and discrimination in which Governments are tasked with developing options for a nationally coordinated approach to stigma and discrimination. Although progress on this action is delayed, the NMHC considers that the development, implementation, and monitoring and reporting of a specific stigma reduction strategy will make all governments more publicly accountable.

Building on current work under the Fifth Plan, the NMHC encourages the national approach to stigma reduction to include other appropriate evidence-based approaches beyond awareness raising activities. The approach would also benefit from strengthening the engagement of consumers and carers, and the inclusion of expertise in communications and public health messaging. The NMHC would welcome the opportunity to take a lead role in coordinating this work to reduce the current high levels of stigma in Australia.

Draft Recommendation - 21.3 Approach to suicide prevention

The NMHC supports the draft recommendation for the current trials that follow a systems approach to suicide prevention to be evaluated. The NMHC acknowledges the work that has been conducted in each of the trial sites and supports bringing the information from the various suicide prevention trials together to identify the specific improvements, resources and service developments that can be applied nationally. This will ensure that benefits from each trial site are realised for the improvement of the national mental health and suicide prevention system for the benefit of all Australians. While the Productivity Commission has made this a medium term recommendation, the NMHC suggests this action should be undertaken as a priority so the evaluation findings can be applied to funding decisions in a timely manner. This approach will require all stakeholders involved in the various suicide prevention trials to contribute to the development and application of an evaluation framework that supports sharing of data and outcomes across the sites.

Recommendation 40. The Productivity Commission's Final Report to make the evaluation of the suicide prevention trial sites a priority so the evaluation findings can be applied to funding decisions in a timely manner.

Recommendation 41. The Productivity Commission's Final Report make a recommendation for all stakeholders involved in the suicide prevention trial sites to support the development and implementation of an evaluation framework for a meta-analysis across trial site findings and for translation into recommendations that can be applied across all Australian regions and jurisdictions.

Draft Recommendation - 22.2 A new whole-of-government mental health strategy

The NMHC supports a whole-of-government cross-portfolio and multijurisdictional approach to mental health and suicide prevention, and the formal mechanisms to allow this. The NMHC seeks clarification on how the Productivity Commission proposes to position the new National Mental Health Strategy in relation to existing and planned national mental health policy, such as Vision 2030, the Sixth Plan, and the National Suicide Prevention Implementation Strategy.

The NMHC supports the recommendation to monitor, evaluate and report annually on the progress of the Strategy, but notes that this is based on evaluating the implementation of the activities and initiatives that are formulated under the strategy. As important, is evaluating the effectiveness of the strategy, ensuring that the strategy has achieved what it said it was going to do. The NMHC suggests the Productivity Commission articulates the need to evaluate the strategy and its implementation in the Final Report.

Recommendation 42. The Productivity Commission's Final Report makes the NMHC responsible for the monitoring, evaluation and reporting of the National Mental Health Strategy.

Recommendation 43. The Productivity Commission's Final Report recommends the National Mental Health Strategy and National Mental Health and Suicide Prevention Agreement have a cross-portfolio and multijurisdictional approach and are adopted by all governments.

Draft Recommendation - 22.3 Enhancing consumer and carer participation

The NMHC supports the recommendation for the monitoring and reporting on total expenditure by individual jurisdictions on systemic advocacy in mental health provided by peak representative bodies. The NMHC notes that reporting on expenditure for peak body advocacy does not equate to building lived experience and co-production capabilities. Any monitoring, evaluation and reporting

of this action would depend on the ability to access relevant data, including at a minimum the data described in the medium term goal of this recommendation.

Conclusion

The changes recommended in the Draft Report are substantial and outline a path towards long-term reform of the mental health system. In this submission, the NMHC has highlighted some key areas for the Productivity Commission to consider to strengthen the whole-of-government and community-based approach to mental health and suicide prevention.

The NMHC welcomes ongoing conversations with the Productivity Commission on the Final Report, the reform priorities, and the future role of the NMHC. In particular, the important and complementary link between Vision 2030 and the directions of the Productivity Commission Final Report.

In a sector that some describe as suffering "review fatigue" it is essential that the Productivity Commission's final recommendations for system reform are action oriented, appropriately prioritised and risk-assessed, and accompanied by clear implementation pathways. The NMHC encourages the Productivity Commission to consider the issues raised in this submission and looks forward to working together to ensure the reforms enable all Australians to live a contributing life.

List of recommendations

Recommendation 1. The Productivity Commission consider *Vision 2030: Blueprint for Mental Health and Suicide Prevention* and how it may be relevant to the Final Report.

Recommendation 2. The Productivity Commission's Final Report include additional content incorporating the full range of principles comprising recovery to better address the ongoing needs of those experiencing poor mental health.

Recommendation 3. The Productivity Commission's Final Report make a recommendation to prioritise research on recovery to consolidate the evidence-base for recovery orientated practice, based on, and with, critical contribution from those with a lived experience.

Recommendation 4. The Productivity Commission's final report should include a more detailed and stronger focus on building long-term system improvements that are based on wellness, recovery and self-management of mental health for individuals, families and communities.

Recommendation 5. The Productivity Commission's Final Report make a recommendation to expand the scope of mental health service mapping frameworks and service planning frameworks to include recovery orientated services.

Recommendation 6. In addition to considering the necessity of a community-based care policy and funding framework within the mental health system (as referenced in Vision 2030), the Productivity Commission's Final Report include a definition of community services and recommendations that strengthen the dual and aligned roles of community and community services.

Recommendation 7. To enable long-term shift in mental health outcomes in Australia, the Productivity Commission's Final Report recommend that the underlying factors of mental illness are routinely addressed in prevention, treatment and support policy and programs across whole-of-government activities.

Recommendation 8. The Productivity Commission's Final Report address the specific needs of populations such as children, older people, and diverse populations in any model of care presented in the final report.

Recommendation 9. The Productivity Commission's Final Report include a recommendation on the Australian Government's role in a policy commitment to a coordinated national approach to the mental health care of older people.

Recommendation 10. The Productivity Commission's Final Report consider how the mental health and suicide prevention system reform has the capacity and capability to meet and respond to future expected and unexpected demands on the system.

Recommendation 11. The Productivity Commission's Final Report address the options as to how to coordinate a cross-portfolio and whole-of-government approach to mental health and the mechanisms that will enable a such an approach to mental health policy and provide strategic oversight to investment.

Recommendation 12. The Productivity Commission's Final Report include detail on stakeholder engagement during the implementation of reforms.

Recommendation 13. The Productivity Commission's Final Report include a recommendation to ensure continuity of service for people affected by new or changed funding arrangements.

Recommendation 14. The Productivity Commission's Final Report include a recommendation that work to develop the MBS evidence-base include specific outcomes that are integrated into measurement efforts across the system; using a co-design process involving all relevant stakeholders.

Recommendation 15. The Productivity Commission's Final Report include a recommendation for the Australian Government to produce an implementation plan in support of the National Mental Health Workforce Strategy.

Recommendation 16. The Productivity Commission's Final Report include additional content in the final report on the value and contributions of the peer workforce.

Recommendation 17. The Productivity Commission's Final Report include a recommendation for research to be conducted as a priority to consolidate the evidence-base for the peer workforce.

Recommendation 18. The Productivity Commission's Final Report recommendations about single care plans ensure that mental health care plans are implemented based on consultation and co-design with the consumer and all relevant stakeholders for that consumer; these plans should also cover physical health checks and support the appropriate and informed sharing of a consumer's physical health information.

Recommendation 19. The Productivity Commission's Final Report explicitly address the need to integrate housing and homelessness policies and mental health policies.

Recommendation 20. The Productivity Commission's Final Report include a recommendation to build the evidence base for early intervention and prevention initiatives such as justice reinvestment and health justice partnerships.

Recommendation 21. The Productivity Commission's Final Report include a recommendation for the Australian Government to encourage Primary Health Networks to extend the contract length for existing psychosocial support services who can demonstrate efficacy and suitability in providing services in their region, and where feasible, enter into longer-term contracts when commissioning services with new providers.

Recommendation 22. The Productivity Commission's Final Report include a recommendation that the Australian Government and state and territory governments ensure that in the long-term, people who apply, or who are found ineligible, for the NDIS have access to adequate psychosocial support services.

Recommendation 23. The Productivity Commission's Final Report include a recommendation for a national evaluation that explores barriers to applying for the NDIS, as well as the availability and access to psychosocial support for people who do not apply or who are ineligible for the NDIS.

Recommendation 24. The Productivity Commission's Final Report recommend the National Children's Mental Health and Wellbeing Strategy be used to guide future funding, program and policy decisions.

Recommendation 25. The Productivity Commission's Final Report strengthen the recommendation regarding universal perinatal screening and perinatal national minimum dataset to ensure it includes the need for explicit referral pathways and identified services, and screening is conducted at optimal timing.

Recommendation 26. The Productivity Commission's Final Report strengthen the recommendations around early childhood checks and early childhood educators to ensure that they are underpinned by specialised child mental health services supporting community and primary health care.

Recommendation 27. The Productivity Commission's Final Report recommends the Australian Government reviews government service policies and processes to meet the needs and improve the experience of vulnerable consumers.

Recommendation 28. The Productivity Commission's Final Report recommends the outcomes of reviews, evaluations or monitoring relating to the improvements of standards and practices in the insurance sector be made public.

Recommendation 29. The Productivity Commission's Final Report strengthen the recommendation regarding availability of aftercare services to include people experiencing suicidal ideation in the absence of a suicide attempt, incorporating an evidence-based approach and best practice.

Recommendation 30. The Productivity Commission's Final Report recommend the National Workplace Initiative be used to guide and inform future funding, program and policy decisions.

Recommendation 31. The Productivity Commission's Final Report strengthen the recommendation to enhance consumer and carer involvement in all aspects of system planning, design, monitoring and evaluation, by providing detail on how this can be achieved.

Recommendation 32. The Productivity Commission's Final Report includes recommendations that ensures any new funding models can support a community needs approach and are able to fund services across the whole stepped care model.

Recommendation 33. The Productivity Commission's Final Report includes advice on how economic modelling can be used to inform the ongoing monitoring, evaluation and reporting of the mental health and suicide prevention sector.

Recommendation 34. The NMHC supports the Productivity Commission's recommendations for the NMHC to independently monitor, evaluate and report on the mental health and suicide prevention system and notes the need to identify the mechanisms to support this responsibility.

Recommendation 35. The Productivity Commission's Final Report needs to make short-term recommendations that support the NMHC to immediately conduct the independent monitoring, evaluation and reporting role.

Recommendation 36. The Productivity Commission's Final Report should refer to the NMHC role as monitoring, evaluation and reporting.

Recommendation 37. The Productivity Commission's Final Report includes a stronger definition of an outcome framework and incorporates the Contributing Life Framework and the relationship of this framework to the monitoring, evaluation and reporting actions for the NMHC.

Recommendation 38. The Productivity Commission's Final Report notes that the evaluation framework will be co-designed with all relevant stakeholders including consumers and carers, and that reporting of agreed outcomes are to be made public.

Recommendation 39. The Productivity Commission's Final Report considers making recommendations to ensure national data quality and consistency is improved as a priority of any national strategy or agreement.

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Recommendation 41. The Productivity Commission's Final Report make a recommendation for all stakeholders involved in the suicide prevention trial sites to support the development and implementation of an evaluation framework for a meta-analysis across trial site findings and for translation into recommendations that can be applied across all Australian regions and jurisdictions.

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Recommendation 43. The Productivity Commission's Final Report recommends the National Mental Health Strategy and National Mental Health and Suicide Prevention Agreement have a cross-portfolio and multijurisdictional approach and are adopted by all governments.

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