Response to the *Strengthening the National Mental Health Commission and National Suicide Prevention Office Discussion Paper.*

November 18, 2024.

Acknowledgement of Country

The Mental Health Lived Experience Peak Queensland (MHLEPQ) respectfully acknowledges and honours the Traditional Custodians of the Lands and Waters throughout Queensland. We thank the Elders—past, present, and emerging—for their wisdom and enduring strength.

We recognise that the legacy of colonisation has profoundly impacted First Nations peoples, contributing to unique and significant experiences of trauma within the mental health and suicide prevention systems. Colonisation has enforced systems of racism, stigma, and discrimination, leading to intergenerational social disadvantage and marginalisation. These historical and ongoing injustices have compounded the challenges faced by First Nations (Aboriginal and / or Torres Strait Islander) peoples, affecting their social and emotional wellbeing.

We acknowledge the enduring resilience and resistance of First Nations peoples in the face of these adversities. We respect their rights and autonomy to lead their healing journeys, guided by their beliefs and traditional practices and connectedness to Country, family, and spirit. .

Recognition of Lived Experience

The MHLEPQ recognise the expertise and leadership of people with lived and living experience of mental ill-health, distress and suicidality, and who have experienced harm within the mental health and suicide prevention systems. We respect the autonomy and dignity of people to advocate for systemic change towards more equitable support

We are guided by and work with MHLEPQ members who have lived experiences, expertise and leadership and support their collective right to challenge the harmful impacts of those systems. We trust in the vision and recommendations of people with lived experience and believe their insights have the power to create lasting change.

Human rights statement

The MHLEPQ recognise the inherent right of people with lived experience to be treated with dignity, protected from torture and cruel, inhuman, or degrading treatment, and to live free from discrimination and stigma according to their cultural determination. This right includes access to support addressing the social determinants of social and emotional wellbeing such as adequate housing, a clean and sustainable environment, and health services that are affordable, effective, and culturally safe.

Mental health is a fundamental human right and we are committed to advancing a just and equitable society where every individual can thrive, with particular attention on the unique social and emotional needs of the most marginalised communities. Human rights in mental health are both a constitutional and operational principle of the MHLEPQ and a central focus of our advocacy efforts. We examine the legal protections and policies affecting lived experience communities to ensure their rights are upheld and that they are not excluded or marginalised within the mental health and suicide prevention systems.

Who are the MHLEPQ?

The Mental Health Lived Experience Peak Queensland (MHLEPQ) is an initiative funded by the Mental Health, Alcohol and Other Drugs Branch, Department of Health. Our organisation was created in July 2021 and moved to direct contracting with Queensland Health on January 1st, 2023 (formerly auspiced by the Queensland Mental Health Commission).

The MHLEPQ was established to provide advice and advocacy informed by people with lived experience of the Queensland mental health system with a specific focus on those who are socially disadvantaged and marginalised. Our work is based on the principles of ***equity, access, cultural safety, recovery,*** and ***human rights***.

MHLEPQ is a member of the National Mental Health Consumer Alliance, where other state and territory consumer peak bodies meet to coordinate on shared issues, including issues relating to Commonwealth policy and government-funded services.

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Key Messages

General and values-based considerations
1. **Addressing the social determinants** and root causes of mental ill-health, illness and suicidal distress must be included as a constitutional focus of both organisations.
2. **Whole-of-government culture change** is required to reform existing systems toward person-centred, recovery-oriented and culturally safe paradigms, where support is responsive to people's sociocultural preferences, and away from biomedical/clinical dominance.
3. **Lack of cohesion and streamlined implementation** of Commonwealth strategy and funding and state/territory application within the mental health and suicide prevention systems. Efforts to address this through the *National Mental Health and Suicide Prevention Agreement* and derivative *Bilateral Agreements* have been demonstrably slow.
4. **A human rights-based approach** at the constitutional, governance and operational levels of both organisations is a legal and ethical imperative that should be visible to the public in policy and practice.
5. **Extensive engagement with Aboriginal and Torres Strait Islander communities** concerning First Nations' priorities for their social and emotional wellbeing should be sought, including inquiring about the relevancy of both organisations for their communities.
6. **Expansion of lived and living experience** engagement, leadership and genuine co-design and collaboration must continue to be a priority of the reform process.
7. **Reforms must prioritise** accountability (political, fiscal, and toward communities); equitable access; affordability; system collaboration,

coordination and streamlining; quality data management; and outcomes monitoring and reporting.

Specific responses to the four key sections

8. **Two reformed structural options toward independent statutory** powers and functions are provided as Options 5 and 6 (see Appendices 5 and 6). The MHLEPQ rejected the four (4) options provided in the Discussion Paper due to the suggested placement of both organisations within the Department of Health. Options 5 and 6 both advocate for the previous NMHC and NSPO sitting outside of Health.

9. **A priority reform objective** should be to increase the monitoring and reporting powers of the mental health and suicide prevention systems[1], in addition to the advisory roles of the previous structures. This will support a focus on creating a "culture of transparent evaluation"[2].

10. **We support the recommendation** of the CEO of Mental Health Australia[3] that whole-system data collection, synthesis and reporting from all jurisdictions should be within the remit of the NMHC.

11. **Cohesive implementation of existing evidence and strategic action plans** should be prioritised by the reformed organisations. The MHLEPQ advise following the pertinent recommendations from existing inquiries and reviews, including but not limited to:

    a. Productivity Commission 2024, *Review of the National Agreement on Closing the Gap,* Study Report, Volume 1[4].
    b. Productivity Commission 2020, *Mental Health,* Report no. 95, Canberra.
    c. The National Mental Health & Suicide Prevention Agreement and Bilateral Agreements.

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[1] Picone, D., & Crawshaw, K. (2023). Independent Investigation into the National Mental Health Commission Report. Available here.
[2] Including the Productivity Commission's 2020 report no. 95, *Mental Health,* Canberra, p.59.
[3] https://mhaustralia.org/civicrm/mailing/view/?id=2303&reset=1
[4] Productivity Commission 2024, *Review of the National Agreement on Closing the Gap,* Study report, volume 1, Canberra. Available at https://www.pc.gov.au/inquiries/completed/closing-the-gap-review/report/closing-the-gap-review-report.pdf

12. **The MHLEPQ supports and advises the uptake of recommendations** from multiple reports on the culturally safe partnership and inclusion of First Nations communities and lived experience communities, including the Productivity Commission's *Review of the National Agreement on Closing the Gap; Mental Health Inquiry Report;* and the Independent Investigation into the NMHC report.
13. **Powers to hold the Government to account** for evidenced engagement and partnership with people with lived and living experience should be within the legislated functions of each new structure.
14. **A strengthened focus on organisational culture change** to support partnership with lived experience, expertise and leadership should be evident in both organisations. The MHLEPQ recommend that executive power be attributed to lived experience leadership to direct consumer engagement and participation to the full extent possible.
15. **We suggest a range of statutory policy functions** for both organisations across Health and Non-Health portfolios, particularly in the areas of wellbeing, prevention and public health promotion.
16. **We advocate for multiple statutory Commissioners (identified)** with powers to set strategic direction. Human rights expertise should be present within the Commissioners to seed an organisational culture of human rights within the mental health and suicide prevention systems.

Introduction

We welcome the opportunity to contribute to phase two (2) of the reform discussions about the structure and positioning of the National Mental Health Commission (NMHC)and the National Suicide Prevention Office (NSPO) for increased impact and success. The Mental Health Lived Experience Peak Queensland (MHLEPQ) works with and for people with lived and living experience (LLE) of mental ill-health, distress and suicidality and is deeply invested in the successful reform of both organisations.

We applaud the Australian Government for responding to the media attention with an independent review of the performance of both organisations, as well as their subsequent action to pause what wasn't working well. The MHLEPQ believe that full public transparency and the willingness to critique, reflect and reassess the functioning of these entities was an important decision to make. We value the opportunity to understand what didn't work, at the same time as being part of reimagining what "best" would look like for both organisations.

Our Approach to this Submission

Staff drew on their institutional and sectoral knowledge to consider the four (4) key sections described in *Strengthening the National Mental Health Commission and National Suicide Prevention Office* (the Discussion Paper):

1. Reform Objectives
2. Role and Function
3. Institutional Settings
4. Governance and Advisory Structures

The MHLEPQ liaised with the National Mental Health Consumer Alliance to gain insight into the thinking and recommendations of other state and territory consumer peak bodies. The draft response was then extensively reviewed by members with experience and expertise in the field and their perspectives were integrated into the MHLEPQ submission. Verbatim

quotes from MHLEPQ members were included (in green font) to support our findings with lived experience narratives. Members contributed to several drafts iteratively until satisfied with the final draft.

General Context

Addressing the social determinants and root causes of mental health and suicidal distress must continue to grow as a major focus of both organisations. We believe this means that the scope of the Department of Health and Aged Care is insufficient to provide the best-fit position for either organisation. In addition, we must note that while the two organisations have overlapping scopes, the sphere of suicide prevention should not be conflated with or subsumed by mental health and vice versa.

From my perspective not everyone who has a mental illness experiences suicidality and not everyone who experiences suicidality has a mental illness, therefore option five should acknowledge standalone independence for both NSPO and NMHC. To quote Suicide Prevention Australia "how can we truly address suicide prevention if we're only looking at it through a mental ill-health lens?"

~MHLEPQ member~

While our members question the value of national and state/territory Mental Health Acts, and some suggest they should be repealed, there is an obvious discrepancy between the presence of national and state/territory Mental Health Acts and the absence of Suicide Prevention Acts nationally and state/territory-wide (excepting South Australia).

Whole-of-government culture change is required to reform existing systems toward person-centred, recovery-oriented and culturally safe paradigms, where support is responsive to people's sociocultural preferences. We know that biomedically-dominated frameworks and clinically-centred models of care don't work for many people and too often breach their human rights to dignity and autonomy. The MHLEPQ supports widespread recommendations to uphold and protect human rights in the

mental health and suicide prevention systems, led by people with lived and living experience:

"Consider system design changes that are person-centred and evidence based to drive meaningful improvement in outcomes that matter to people, supported by innovative, efficient and flexible funding arrangements"[5].

The MHLEPQ also note the *Independent Investigation Report* finding concerning a psychologically unsafe work environment, and the challenges for the inaugural Director of Lived Experience within their role at the Commission. It is common for people in lived experience-identified roles to encounter an organisational culture that lacks what is required to sustain tenable employment, from entry level through to senior and leadership positions.

There are issues with cohesion and streamlined implementation of Commonwealth strategy and funding and state/territory application. The extensive, decentralised and scattered metro-centric nature of pilot projects, community organisations, NGOs and not-for-profits across states and territories makes data and information gathering haphazard and extremely difficult to interpret, and measurement of state and nationwide mental health and suicide prevention 'progress' ineffective.

[…] one of the fundamental issues (which will not be solved easily) is the presence of the Federation Model of government and the distribution of powers and funding across each of the States and Territories […] This simply does not allow for true collaboration (vertically or horizontally) and hence many of the aims and recommendations etc are simply of an 'Advisory' nature and not enforceable

~MHLEPQ member~

The *National Mental Health and Suicide Prevention Agreement* (NMHSP Agreement) and derivative *Bilateral Agreements* were developed to address the lack of cohesion, however, progress has been demonstrably

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[5] National Mental Health and Suicide Prevention Agreement: Part 2 – Principles, objectives, outcomes and outputs, p.7 (g)

slow (see Appendix 3 for member comments and observations on the NMHSP Agreement, pp. 25-27).

Strategy and funding are provided by the Federal Government and the execution and application of the funding is empowered to each State and Territory to administer. This simply does not allow for true collaboration (vertically or horizontally) […] Refer to the National Mental Health & Suicide Prevention Agreement and Bilateral Agreements. After nearly 4 years, little progress has been accomplished due to the strategies and direction that each State and territory pursues.

~MHLEPQ member~

Cohesive implementation of existing evidence and strategic action plans should be prioritised by the reformed organisations. This will ensure that commitments to the public are kept, and confidence in governments to work in partnership with communities, grows. Quality improvement depends on resisting the urge to repeat and duplicate existing findings and instead focus on delivering and monitoring outcomes decided in documents such as the *National Mental Health and Suicide Prevention Plan*[6] and the *Productivity Commission's Mental Health Report* (Vol 1, p.63):

[Recommendation 24]: "establish an evaluation and monitoring system that focuses on outcomes, and ensures that mental health services are effective in supporting recovery"

Values-based Considerations

This section provides principled advice on the establishment of the NMHC and NPSO underpinned by the five MHLEPQ values that guide our work: ***Equity, Access, Cultural Safety, Recovery*** and ***Human Rights.***

A human rights-based approach at the constitutional, governance and operational levels of both organisations is a legal and ethical imperative. In the absence of a National Human Rights Act (recommended by the Parliamentary Joint Committee on Human Rights)[7], the MHLEPQ

[6] Australian Government Department of Health and Aged Care 2021. *Prevention Compassion Care: National Mental Health and Suicide Prevention Plan.* Available here

[7] Parliamentary Joint Committee on Human Rights: Inquiry into Australia's Human Rights Framework, available here

recommends that the Australian Human Rights Commission be used in an advisory capacity to support the alignment of organisational human rights policy. International human rights legislation, including but not limited to the United Nations Convention on the Rights of Persons with Disability (CRPD)[8] and the Optional Protocol to the Convention against Torture (OPCAT)[9] should be adopted.

The MHLEPQ recognise the crucial importance of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)[10] for First Nations peoples' rights to cultural self-determination. There should be extensive engagement with Aboriginal and Torres Strait Islander communities concerning First Nations' priorities for their social and emotional wellbeing. We suggest ensuring that all available First Nations-led evidence for cultural determination underpins all further activity relating to the reform of both organisations. This would include understanding whether the organisations are relevant for First Nations communities, and if so, what powers, functions and structural options best meet their needs. We advocate for applying the recommendations to Government of the *Review of the National Agreement on Closing the Gap*[11] as high-level guidelines:

1. Power needs to be shared.
2. Indigenous Data Sovereignty needs to be recognised and supported.
3. Mainstream government systems and culture need to be fundamentally rethought, and
4. Stronger accountability is needed to drive behaviour change.

[8] https://humanrights.gov.au/our-work/disability-rights/united-nations-convention-rights-persons-disabilities-uncrpd
[9] https://humanrights.gov.au/our-work/rights-and-freedoms/projects/opcat-optional-protocol-convention-against-torture
[10] https://humanrights.gov.au/our-work/un-declaration-rights-indigenous-people
[11] For example, Productivity Commission (2024) Study report, Vol. 1: Review of the National Agreement on Closing the Gap

Lived and living experience inclusion and leadership remain outside the parameters of genuine co-design and collaboration and often fall into the category of nominal consultation. We call for the serious consideration and application of recommendations 54 and 55 of the NMH&SP agreement, which involves systematic collaboration with people with lived experience of mental ill health and/or suicide and their families and carers within priority populations. In addition, all relevant national and interjurisdictional mental health commissions, peak bodies and committees must be consistently involved in the developmental reforms:

Let's hope that MHLEPQ (and others) somehow obtain a seat at the table to be able to advocate for the voices of lived experience in both development and supporting of the developed agreement.

~MHLEPQ member~

Major accountability issues are part and parcel of organisations with advisory-only roles. There are large numbers of published reports, agreements, strategies and frameworks that have not been implemented, evaluated, monitored and reported transparently. In addition, there are many Royal Commissions and Public Inquiries whose recommendations are not taken up and actioned by Governments. Our advocacy for executive powers and functions of the reformed NMHC and NSPO that raise the accountability bar for Governments and resource-holders are based on the following current limitations:

a. ***Lack of political accountability:*** people with lived experience distrust more strategic work being actioned without clear optics on implementation, evaluation and monitoring. As one member said about the Royal Commissions and Inquiries, "another example of the 'advisory' capacity approach as opposed to executable action approach". Cross-governmental approaches to longer-term programmes of work must feature more strongly in the mental health and suicide prevention systems of the future.
b. ***Lack of fiscal accountability:*** The Federal Government spends approximately $10 billion per annum in the context of increasing

need for mental health and suicidal distress support. Where is the evidence for the return on investment into both systems of public funds?

c. ***Accountability to people with lived and living experience and the Consumer movement:*** the entire sector is aware of their mandatory and human rights-based obligations to people with LLE. Crucial areas where executive powers must ensure delivery of results to the community include, but are not limited to:
   - **Engagement**: lived experience advice; capacity for co-design; lived experience employment opportunities at all levels including executive leadership; implementation of lived experience knowledge and expertise in policy, legislation and practice.
   - **Over-reliance on the biomedical model** in decision-making, policy and service delivery must be reformed through integration of person-centred, recovery oriented and culturally safe models based on human rights legislation and frameworks.
   - **Organisational cultural change** toward a human rights-based approach with person-led, culturally safe and strengths-based models, and
   - **Appropriate and sustained investment** in the lived experience (peer) workforce and models of care.

Barriers to equitable access for people seeking mental health and suicide support services (prevention, intervention and postvention) remain a crucial issue. Particularly so for marginalised and minority groups, regional, rural and remote-living people and priority populations relating to sexual orientation, gender, socioeconomic status and traumatic circumstances. The NDIS-non-NDIS 'divide' is increasingly impactful for people living with psychosocial disabilities unable to access suitable support.

The unaffordability of private health insurance, increasing public health gap payments and the disadvantage of people living at the lower end of the socioeconomic spectrum are creating an increasingly unsustainable two-tiered health system that further marginalises people seeking mental

health and suicide support services. Despite the espousing of universal healthcare in Australia, people with LLE argue that universality does not extend to mental healthcare or the affordability of suicide prevention/intervention/postvention services.

Challenges to system collaboration occur at multiple crucial junctures that negatively impact cohesive planning, implementation, monitoring and reporting, including:

a. Federal, State and Local Government levels have poor mechanisms for effective communication and collaboration, resulting in poor transferability and scaling of successful programmes.
b. Across Federal Governmental Departments, crucial for effectiveness in the mental health and suicide prevention systems. There needs to be cohesiveness between Health, Housing, Employment, Education, Policing, Justice etc.
c. Disconnect at the inter- and intra-state/territory levels, including disparate approaches between departmental, tertiary/secondary and primary design and service delivery
d. The lack of sustainable funding for successful pilot programmes that quickly fall off the funder's radars, leaving more established (often unevaluated) programmes with large, approved budgets continuing to be resourced.

Poor coordination and over-supply of organisations across all communities (particularly in metropolitan areas) need to be rationalised and streamlined, leading to better use of funds and matching to consumer demand. There is a disproportionate representation of data from metro organisations as well as a lack of standardised data management.

Quality and streamlined data management is necessary for transformational change and transparency about the Commonwealth-State digital strategy is important. "*Garbage in, Garbage out"* relating to data insufficiency should be a crucial focus. Data points that reflect the

social determinants and evidence-based drivers of mental health and suicide prevention must be derived. Data congruence across federal and state jurisdictions is important for political accountability.

Measurement and reporting should be focused on outcomes, not outputs. Outputs generally reflect short-term, system-based indicators. Outcomes should focus on long-term indicators impacting consumers and people with LLE. Lived experience expertise must be engaged to advise on data points including:

a. **Holistic wellbeing**: mental, emotional, physical, social, spiritual, financial and environmental factors.
b. "**Universal Mental Healthcare System**" variables
c. **Human rights and equity standards** that must be reached, including access, availability, affordability, quality and safety.
d. **"No wrong door"** policies that provide person-led, strengths-based and culturally safe supports with access to lived experience (peer) workforces.

Response to four (4) Key Sections in the Discussion Paper

1. Reform Objectives

Given that a non-statutory office within the Department of Health and Aged Care is not a viable option and has not truly delivered the necessary continuous improvement [...] it is recommended that these two organisations be separated [from the Department] and provided with the appropriate funding, resources and executive powers to address the critical and deteriorating national position of Mental Health and Suicide in Australia

~MHLEPQ member~

- To meet the reform objectives, we believe that both organisations must have increased inquiry and monitoring powers to hold the Commonwealth Government accountable for the performance of the mental health and suicide prevention systems.
- We agree with prominent consumer and consumer organisation leaders that the organisations should sit outside of Health to

maintain independence and advise and monitor across government portfolios.

- Statutory independence will ensure evidence about the effective use of mental health and suicide prevention funding exists and is shared, a requirement to bolster public confidence.
- Outcome and accountability indicators should be drawn from existing independent inquiry reports, recommendations and in partnership with the people who use the system. For example:
    - Productivity Commission 2024, *Review of the National Agreement on Closing the Gap,* Study Report, Volume 1.
    - Productivity Commission 2020, *Mental Health,* Report no. 95, Canberra.
    - The NMHSP Agreement and Bilateral agreements.
- The MHLEPQ advocates for engagement and partnership with First Nations communities concerning how they want the organisations to be structured to serve their communities best, if relevant to their social and emotional wellbeing.
- Powers to hold the Government to account for evidenced engagement and partnership with people with LLE should be within the legislated functions of each new structure.

2. Role and Function

- In response to the *Independent Investigation Report* finding of a psychologically unsafe work environment within the NMHC, we recommend that both organisations expand and strengthen their focus on organisational culture change to support partnership with lived experience, expertise and leadership. In addition, executive power must be attributed to lived experience leadership to direct consumer engagement and participation to the full extent possible.
- Both organisations must be given the powers to oversee and monitor whole-of-system connections between Commonwealth and state/territory systems, across national departments, and streamlining between arbitrarily divided community, primary and

tertiary components of the state/territory systems. MHLEPQ notes the multiple recommendations across various inquiries to leverage a person-centred mental health system through streamlining, for example[12]:

"Remove barriers to collaboration within and between different parts of the mental health system, by actively encouraging information sharing and coordination between health service providers (Recommendations 10, 14); by creating systems and processes that bring together the range of treatments and supports that people may choose (Recommendations 10. 12, 15); and by reforming funding, to incentivise better cooperation and collaboration across mental health services (Recommendation 23).

- Action the Productivity Commission (2020) *Mental Health* (Vol. 1, p.58) recommendations about NMHC statutory authority to:
    - Monitor and report on progress towards achieving system-wide outcomes across health and non-health portfolios.
    - Monitor and report on PHN-LHN cooperation or development of Regional Commissioning Authorities.
    - Lead transparent evaluation of significant MH and SP prevention programs funded by governments, including non-health related programs.
- We suggest that the reformed NMHC and NSPO have the power and function to transparently and publicly report Commonwealth Government performance according to the new entities' terms of reference.
- Both organisations should be attributed the function to develop policy and strategy for Government consideration.
- We support the Annual National Report Card process and public reporting and evaluation.
- We recommend increased powers to require information from PHNs, NDIA and entities funded by the Commonwealth.
- Both organisations should have policy roles and functions in wellbeing, prevention and public health promotion. Statutory policy functions, in addition to positioning both organisations outside of the

[12] Productivity Commission report 2020, *Mental Health* Vol.1, 95 p. 64

Department of Health, will support a move away from biomedical imperatives that continue to dominate governments, academia and health systems.

3. *Institutional Settings*

- We advocate for multiple statutory Commissioner(s) with powers to set strategic direction. Advisory-only Commissioners are insufficient and can be delegated to the CE (see more below in 4. Governance and Advisory Structures).
- Membership of the Commission
    - Staff diversity, inclusion, cultural safety, intersectionality.
    - Human rights expertise within Commissioner(s) and Staff knowledge and skillset.
- To reiterate, both reformed organisations should sit outside of the Department of Health and Aged Care which will increase their capacity to advise, monitor and report on all-of-government performance and activity.

4. *Governance and Advisory Structures*

[...] that the newly formed Statutory Body be given the legislative and executive powers to bring about sustainable change, and is not just another Advisory Body, lacking the 'teeth' and influence across the landscape. There is already an oversupply of Government, Non-Government, Not-for-Profit and Community organisations that are in in these advisory spaces.

~MHLEPQ member~

- The MHLEPQ advocates for the establishment of the previous NMHC and NSPO as independent statutory bodies, which could adopt multiple configurations not already included in the Discussion Paper (see Appendix 1: Option 5 and Appendix 2: Option 6). The purpose is to maximise the powers and functions of the Commission(s) in line with other Governmental bodies (such as the Australian Law Reform Commission, Commonwealth Ombudsman and the Aged Care

Quality and Safety Commission), including greater independence, greater accountability to Parliament, and clearer Budget financing.

- **"Option 5" structural reform** (see Appendix 1, p. 25) would establish two new primary non-corporate Commonwealth Entities outside of the Department of Health and Aged Care, reporting directly to Parliament. Primary legislation will set the core functions of the Commissioners of both the National Mental Health Commission and the Suicide Prevention Commission (rather than the CEs). This structural reform would:
    - Allow greater independence of the mental health and suicide prevention systems from Health and support a stronger focus on their social determinants and a necessary shift away from biomedical dominance.
    - Increase the monitoring and reporting powers and functions of both Commissions
    - Enable greater accountability to Parliament
    - Clarify Budget funding objectives and monitoring

  The NSPO would cease to become a non-statutory office and be attributed statutory authority as a primary non-corporate Commonwealth Entity. The NMHC and NSPC would maximise collaboration and partner to ensure low. There would be multiple Commissioners. For example, a Joint Mental Health and Suicide Prevention Commissioner, a Psychosocial Commissioner, a LE Commissioner (to be determined in consultation with LLE).

  The MHLEPQ acknowledge that Option 5 would require increased resourcing compared with Options 1-4 in the Discussion Paper but argues to have more effective structures given the urgency within mental health and suicide prevention systems to improve outcomes for people.

- "**Option 6" structural reform** (see Appendix 2, p. 26): Establish a dual-functioning Commission (the National Mental Health & National Suicide Prevention Commission, NMH&SPC) as a primary non-

corporate Commonwealth Entity outside of the Department of Health and Aged Care, reporting directly to Parliament. Primary legislation will set the core functions of at least two (2) identified Commissioners – one National Mental Health Commissioner and one National Suicide Prevention Commissioner. Neither statutory nor non-statutory structures will feature in the reform. As with Option 5, this structural reform would:
    - Allow greater independence of the mental health and suicide prevention systems from Health and support a stronger focus on their social determinants and a necessary shift away from biomedical dominance.
    - Increase the monitoring and reporting powers and functions of both 'arms' of the Commission: mental health and suicide prevention
    - Enable greater accountability to Parliament
    - Clarify Budget funding objectives and monitoring
- The MHLEPQ advocates the statutory authority and powers to set the strategic direction of the organisations seated within the Commissioner(s) role. The previous arrangement of the Commissioner sitting in predominantly advisory roles with the CE holding statutory power, is insufficient. Administrative and advisory roles would be attributed to the CE.
- We suggest statutory appointments of at least two (2) identified Commissioners for mental health, suicide prevention and consumer experience. Their roles should be legislated in the Commission functions and attributed to the most suitable Commissioner at the time.
- We advocate for the establishment of a legislated committee that includes consumers to advise parliament on Commissioner appointments.
- Functions should be attributed to the National Consumer Peak to hold Commissioners accountable for lived experience inclusion, participation and leadership.

- The MHLEPQ advocate for refreshing nationally agreed governmental commitments to First Nations communities, including but not limited to the *National Agreement on Closing the Gap*[13] and the Productivity Commission's 2024 *Review of the National Agreement on Closing the Gap*[14]*.*

[13] https://www.closingthegap.gov.au/national-agreement/national-agreement-closing-the-gap
[14] https://www.pc.gov.au/inquiries/completed/closing-the-gap-review/report/closing-the-gap-review-report.pdf

Communication

Future communication about this submission or associated matters can be made with:

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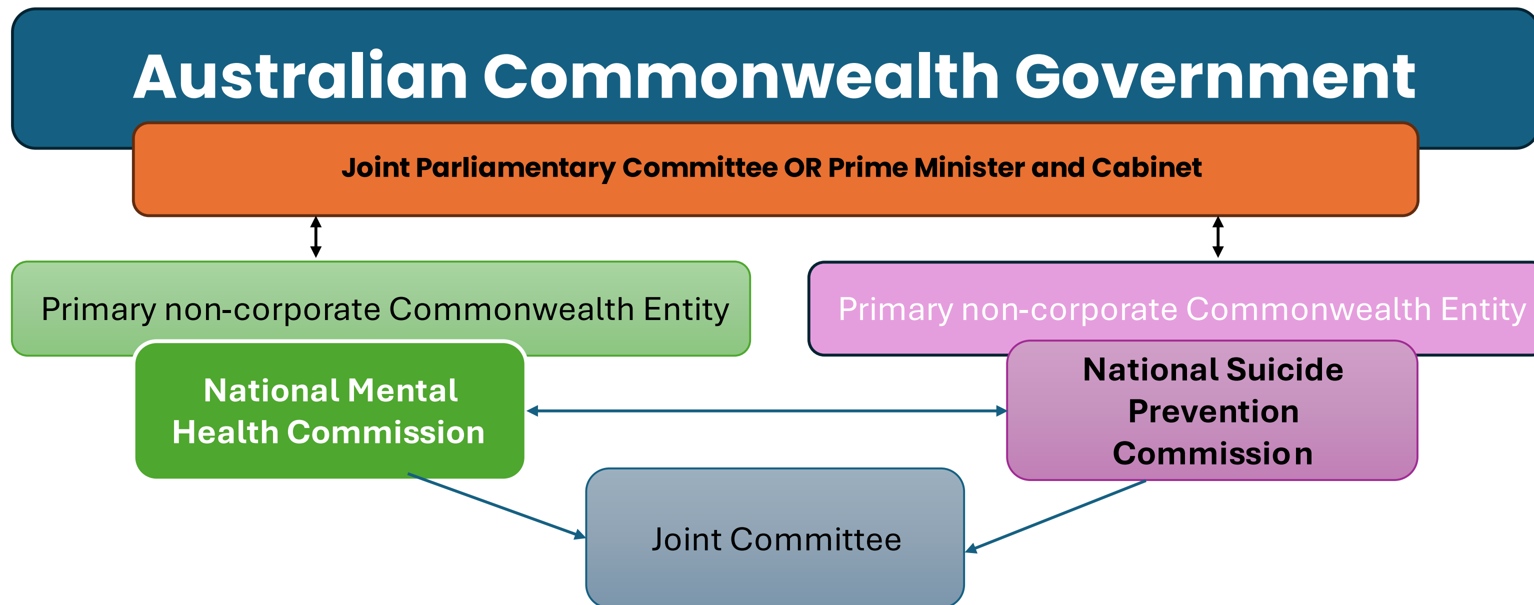
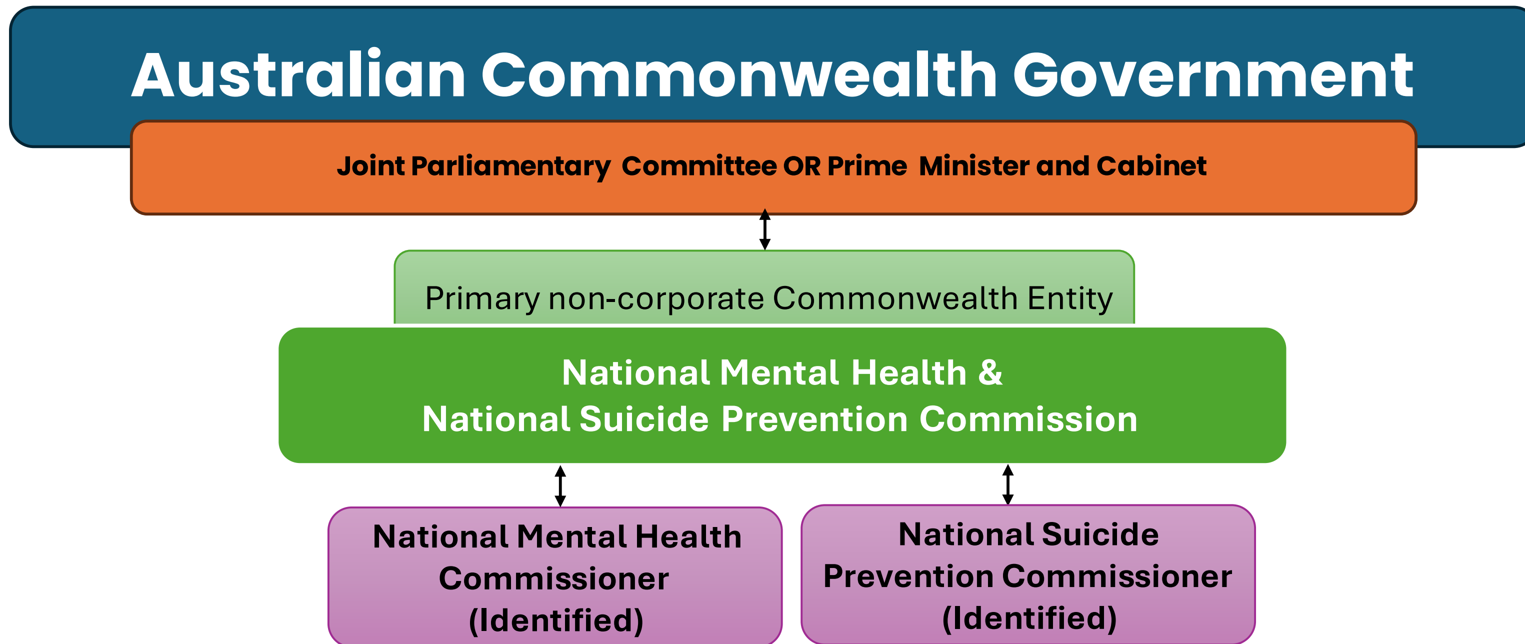
Appendix 1

Option 5: NMHC & NSPO structural reform



Appendix 2



Appendix 3

Lived Experience Comments on the Application of the National Mental Health & Suicide Prevention Agreement

FACTORS	ASSESSMENT	COMMENTS
Must be involvement of people with LE in the development, implementation, oversight, and evaluation of the Agreement.	Not achieved	Lived experience (LE) remain participants, at times in potential consultations, rather than leaders influencing outcomes. The LE group took over 2 years to be formed.
Need for clear accountability, coordination of activity, and transparency of action; need for First Ministers to take responsibility for the outcomes of the Agreement.	Not Achieved	No collaboration across all Departments and under the sole responsibility of Health Ministers. Health System designed for physical health (currently stressed & overloaded), with mental health and suicide prevention simply "add on's" – no infrastructure, training, or expertise at the 'front door' or 'apparent' lack of interest.
Governance & implementation mechanisms must include representation from the sector – drawing on expertise including LE	Not Achieved	Too many frameworks, organisations, new bodies etc. Proposed re-establishment of Mental Health Principles Committee – does not include external representation. Dominated by Bureaucrats, Clinicians and Academics

Focus on activity beyond the Health system & include responses that address social determinants and root causes of mental ill health and suicide, including poverty, trauma etc	Not evident	True collaboration across Federal, State and Territories and across Departments is insufficient.
Evaluation and measurement of outcomes including whole-of-government measures with long term focus	Not evident	As above
Universal set of high-level principles (supported by all sectors)	Evident…but	The principles are missing necessary detail and structure
Reporting – appears voluntary and accountability is internal to Government	Not Achieved	Lacking external oversight and transparency. Lacking external involvement and consultation from the outset – design and implementation.
1992 – First National Mental Health Strategy – What has changed / improved?	???	Abundance of reports, agreements, strategies, frameworks etc – yet limited in terms of progress. Suicide and Mental Health stats continued to climb. There is duplication and lack of clarity. Data collection and reporting processes are centrally driven, top-down and activity-focused (outputs not outcomes) Reporting of outputs doesn't include actual health outcomes or addressing the social determinants. Ongoing lack of service user or carer priorities.

Real life data – to impel systemic quality improvement.	???	Transparency is required about: • Who is presenting for mental health care and why? • Who is not? And why? • Where is the evidence for the types of interventions provided, and their outcomes and subsequent pathways taken by patients? • Impacts on/from across the social sector including housing, education, employment etc. • Poor data parameters and collection reinforce undesirable models of care (e.g. if hospital beds are the currency reported, beds will remain the priority – regardless of all other factors and alternates).
Confused and congested landscape		Accountability and transparency issues: • At least 2 national mental health policies • 5 plus national mental health plans • National Action Plan • Several other national documents • Multiple roadmaps / frameworks • Associated Royal Commissions and Inquiries • Countless recommendations sitting unactioned within shelved reports
Schedule A Working Group	Ineffective	• Overburdened with bureaucratic representatives from each state. • Little lived and living (LLE) representation and appearance that LLE representation was late in inclusion • There was little acknowledgement of LLE input and participation in the meeting I attended (almost tokenistic, I feel) • Communication channels are poor.

ENDS