No. Too much of the existing statement about objectives and functions is implicit, rather than explicit. For example, reforms are designed to ensure "that the NMHC and NSPO are positioned for success". What does success actually look like? And success for whom?

What are the desired outcomes or changes we hope to see in the way Australia responds to mental illness and what is the role the Commission is supposed to execute to reach these outcomes? Another example is that the NMHC is supposed to report "on federal and state s system performance against service expectations". What are these expectations and how were they set?

The existing proposed objectives and functions are not well enough described and lack detail. Fuller explanation of what accountability is, the specific role of the Commission and how it is supposed to drive systemic quality improvement are missing, for example, in relation to candidate mechanisms and subsets of accountability.

NMHC needs to consider implementation science as key role – how does it actually effect change? What theory or theories of change are to be deployed? This means the Commission needs to understand not just what it seeks to change, but how.

This entails deploying Mental Health-

Data analysis:

Data visualization:

Data management:

Understanding of KPIs:

Critical thinking:

Communication skills:

Technical skills:

A key step in the Commission fulfilling its remit is therefore judicious recruitment of requisite skilled staff.

In addition to the technical and other skills listed above, the Commission also needs interdisciplinary clinical staff possessing contemporary evidence informed knowledge and skills, as well as bi-cultural / transcultural and lived experience and family expertise. Researcher skills should include epidemiological, big data, cohort, qualitative, lived experience service user and family expertise.

Lacking these skills, past national report cards have often focused on amorphous or unhelpful 'case studies', rather than publishing actionable, comparable, benchmarked data. There is little if any evidence these report cards permitted useful comparisons or resulted in organisational learning.

It should be noted that the Commission's inception coincided with the Federal Government ceasing to publish the National Mental Health Report Series. This Series was a specifically tailored publication, provided with dedicated resources to enable timely reporting on jurisdictional progress towards agreed goals under the National Mental Health Strategy. It is arguable that failure to replace the Series, in favouring of relying on AIHW and ROGS data, has weakened national accountability for mental health.

The Commission has noted the historical power imbalance in mental health care, leaving lived experience service-users and families often victims of poor care, neglect or human rights abuse.

Placement of any commission under a Department of Health makes establishing a broader, social determinants role much less likely. As with the mental health system generally, this situation makes it much more likely that commissions will undesirably focus on hospitals, beds and other health administrative data (such as Medicare statistics), rather than keep a broader focus.

In relation to statutory authorities, there are advantages to this administrative model. However, as has been proven by several existing commissions, there is quite a difference between having the necessary teeth to demand data, run inquiries, report independently to parliaments, and choosing to use these powers. A statutory authority, holding its own delegations, reporting publicly but administratively linked to Dept of PM&C may well be the optimal arrangement.

See 2. above

Especially now with a peak body established, empowering consumers should not be the focus of the Commission. Rather, they should consider how best to enable lived experience to feed into new accountability. For example, this could usefully focus on establishing systems of real time, validated feedback from consumers and carers. Consumers and carers could be trained to lead, manage and report on a federated system of real time reporting, providing invaluable, direct insight into the changing health and welfare of people with a mental illness, including their experiences of care.

But even armed with this data, actually changing the nature of service provision will need the Commission to have strong and trusted relationships with service providers and professionals. A model or theory of change is necessary to provide the anticipated method and process by which the Commission intends to lead change in mental health.

The Advisory Body needs to fully understand the model of change and the data developed to support it. It could lead change processes locally, making the Commission much more useful to local planners, funders and others who are interested in make change happen where they live.

The Commission's focus should not be about representation or advocacy, but about accountability and change management.

We hope this feedback is helpful. It draws on more than a decade's experience developing and working with commissions. For your additional information, at Appendix 1 is a brief proposal (prepared by authors Rosenberg and Rosen) focusing on options for evaluating the effectiveness and potential synergies between Australia's mental health commissions. Several of these components of inquiry could contribute considerably to the robustness, complementarity, coherence and integrity of these important organisations. It is understood that this paper has been submitted to a meeting of all commissioners where it is receiving some consideration.

We would be happy to discuss the feedback provided here at your convenience.

Alan Rosen and Sebastian Rosenberg have long been proponents of the potential of mental health commissions to function as effective agents for systemic mental health reform. This was derived initially from several review articles

Assoc Prof Sebastian Rosenberg and Professor Alan Rosen, AO.

To propose a project to create a new common approach to evaluating the impact of Australia's mental health commissions. This project would have five components:

1. a brief updated international review of the current status, characteristics, practical achievements and longevity of all Type II / reform-oriented Mental Health Commissions.
2. consideration of the viability of developing a nationally consistent framework and suite of optimal evaluative indicators, quantitative, qualitative and cultural variables and metrics by which to assess the impact of all Australian Mental Health Commissions.
3. to work with all Australian Commissions to establish a new, common platform for reporting and accountability.
4. a comparative analysis of the respective government's enabling functions, delegations and powers of independent data discovery, inquiry and reporting assigned to each Commission.
5. mapping of a pathway to develop a capacity for the Commissions to learn from each other, to more formally collaborate, coordinate and synergize their activities to become more effective in their separate and combined roles, in the service of affected individuals, families and communities.

The idea for this proposal arose following a recent conversation between Ivan Frkovic and Sebastian Rosenberg.

Over the past 15 years or so, Australia has made a globally unique and significant commitment to the concept of mental health commissions, as a way of making further progress on mental health reform. 7 out of 9 jurisidictions have adopted some version of a commission, with the specific arrangements and powers of each body varying.

Most of these organisations have already been subject to some kind of evaluation, either internal (such as here, here and here) or external, such a ¢ ¢ nu

30 years of national and jurisdictional planning in mental health has not led to uniform approaches to service development, monitoring or reporting. Significant variation and gaps remain. In a country as vast as Australia, some of this variation may well be desirable – there is no "one size fits all."

However, what does this variation mean for systemic quality improvement and prevention of discontinuities of care and serial system failures (e.g., Bondi Junction Shopping Mall disaster of April 2024)? How do mental health systems learn from each other and incrementally improve the experience of care for service users, family carers and their clinicians and support providers working in those systems?

Working in conjunction with each Commission, this project would have five key deliverables:

1. A brief international review of the current status, practical achievements and longevity of all Type II / reform-oriented Mental Health Commissions.
2. Consideration of the viability of developing a nationally consistent framework and suite of optimal evaluative indicators, quantitative, qualitative and cultural variables and metrics by which to assess the impact of all Australian Mental Health Commissions. This would include the benefits and limitations of, as well as the opportunities for and obstacles to devising such a framework, which could contribute to improved jurisdictional and national accountability for systemic mental health reform.
3. The third key deliverable would be to work with all the Commissions to establish a new, common platform for reporting and accountability. Different approaches and report cards have been established. Some focus much more on the health system than others, which attempt to address other issues of community interest such as housing, education and employment. Some have well-developed sets of indicators, often with a focus and priority set on mental illness, while others have charters requiring them to be mindful of and to prioritize broader individual and communal mental health and wellbeing frameworks. These variations between districts prevent comparison and make the consistent identification and application of opportunities for systemic improvements more difficult. The key product here would be the coproduction of an initial agreed short-list of candidate common indicators which could guide the shared evolution of a national approach to monitoring and impact reporting by the mental health commissions on the quantity, quality, workforce development and outcomes of Australian mental health services, as well as the allocation, dedication and sustaining of resources for them.
4. The fourth key deliverable would be a comparative analysis of the constructs, delegations and powers assigned to each Commission. The aim would be to understand the extent to which these affect the capability of each organisation to fulfil its mandate. For example, do statutory powers help Commissions deliver change or do they make little difference? These arrangements could include unfettered independent delegations, enabling powers of compulsory data access and discovery, and to initiate independent inquiries and report on their findings publicly or to parliament. Other examples could be budget-holding and the power to commission services at arm's length.

   Understanding the comparative strengths of different models of Commission could enable refinement of individual jurisdictional models, to give them the best chance of success.

5.