Australian Government
National Mental Health Commission

Developing a national mental health and suicide prevention monitoring and reporting framework

National consultation material

16 October – 17 November 2017

Hobart, Canberra, Melbourne, Brisbane,
Sydney, Perth, Adelaide, Darwin

Contents

1 Introduction

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

The Framework will guide the Commission's national independent monitoring and reporting on mental health and suicide prevention over the next five years (2018-22). The Framework will act as a roadmap for the Commission's activities, by capturing the domains[1] that the Commission will monitor and report on at various stages over this timeframe. It will also identify data sources, opportunities for analysis, data development, and reporting formats and frequency. The Framework will include health and social outcomes, system performance and population mental health and wellbeing for consumers, carers, families and support people. Through its monitoring and reporting, the Commission will track the progress of reform commitments, investigate whether they are making a difference and use this information to inform future policy, practice and research priorities.

2 Purpose of this document

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

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

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

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

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

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

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

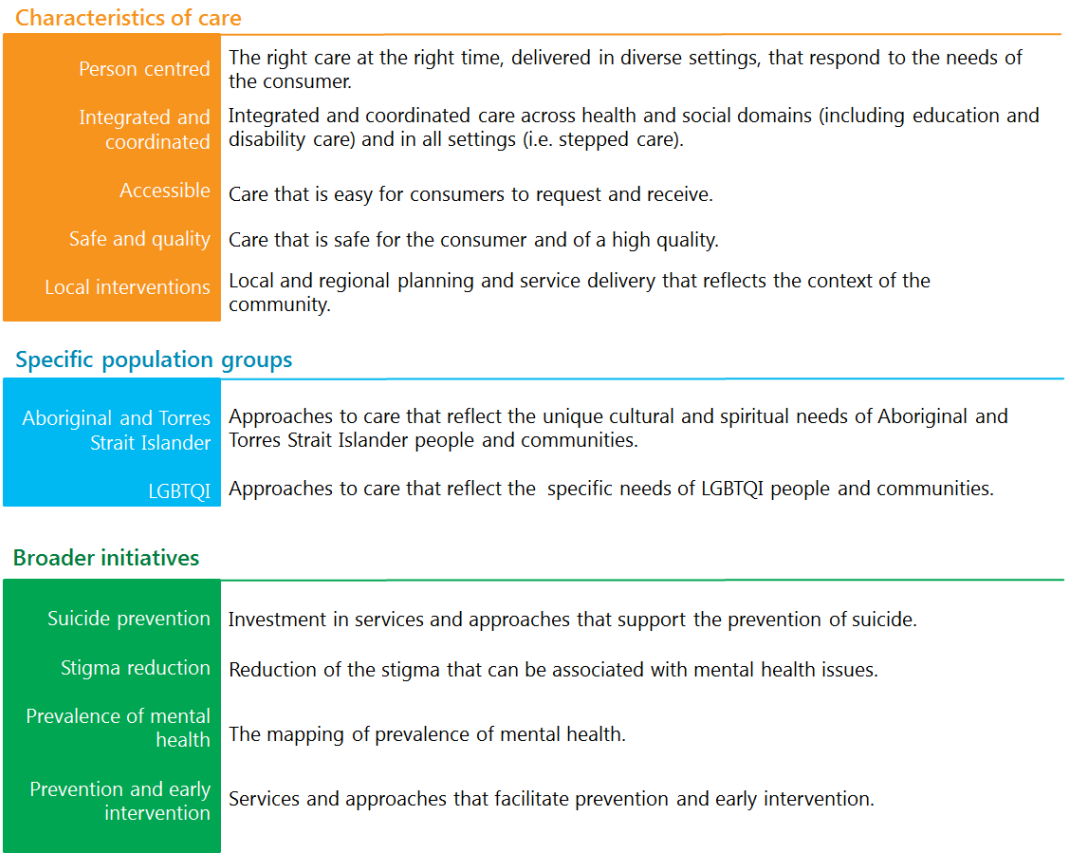
3 Background to the development of the Framework

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

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

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

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

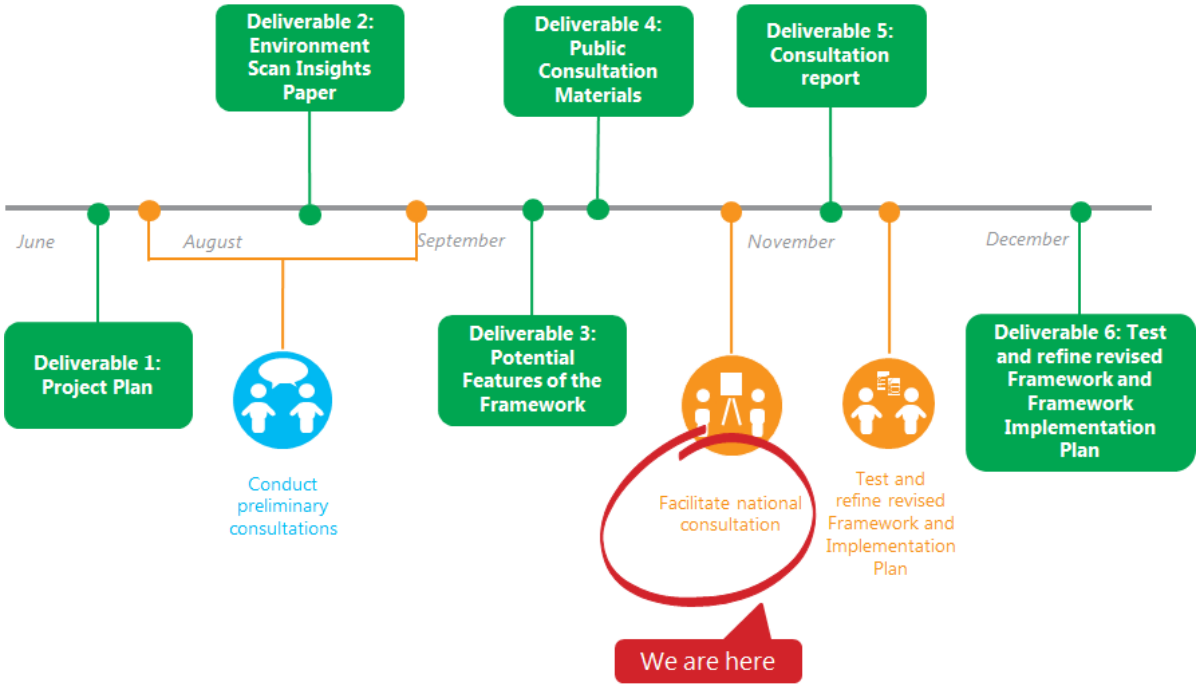


While the Framework will provide a comprehensive overview of the Commission's approach to monitoring and reporting on mental health and suicide prevention, the Commission's capacity to deliver on the entire scope is dependent upon the level of resourcing available to it and competing demands within its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

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

Figure 2 outlines the process underway for developing the Framework.

Figure 2: Work undertaken to date



4 Purpose of the Framework

The purpose of the Framework is to provide national independent monitoring and reporting of mental health and suicide prevention.

Table 1 expands on what the Framework aims to achieve**.**

Table 1: What the Framework aims to achieve

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

5 Potential features of the Framework

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

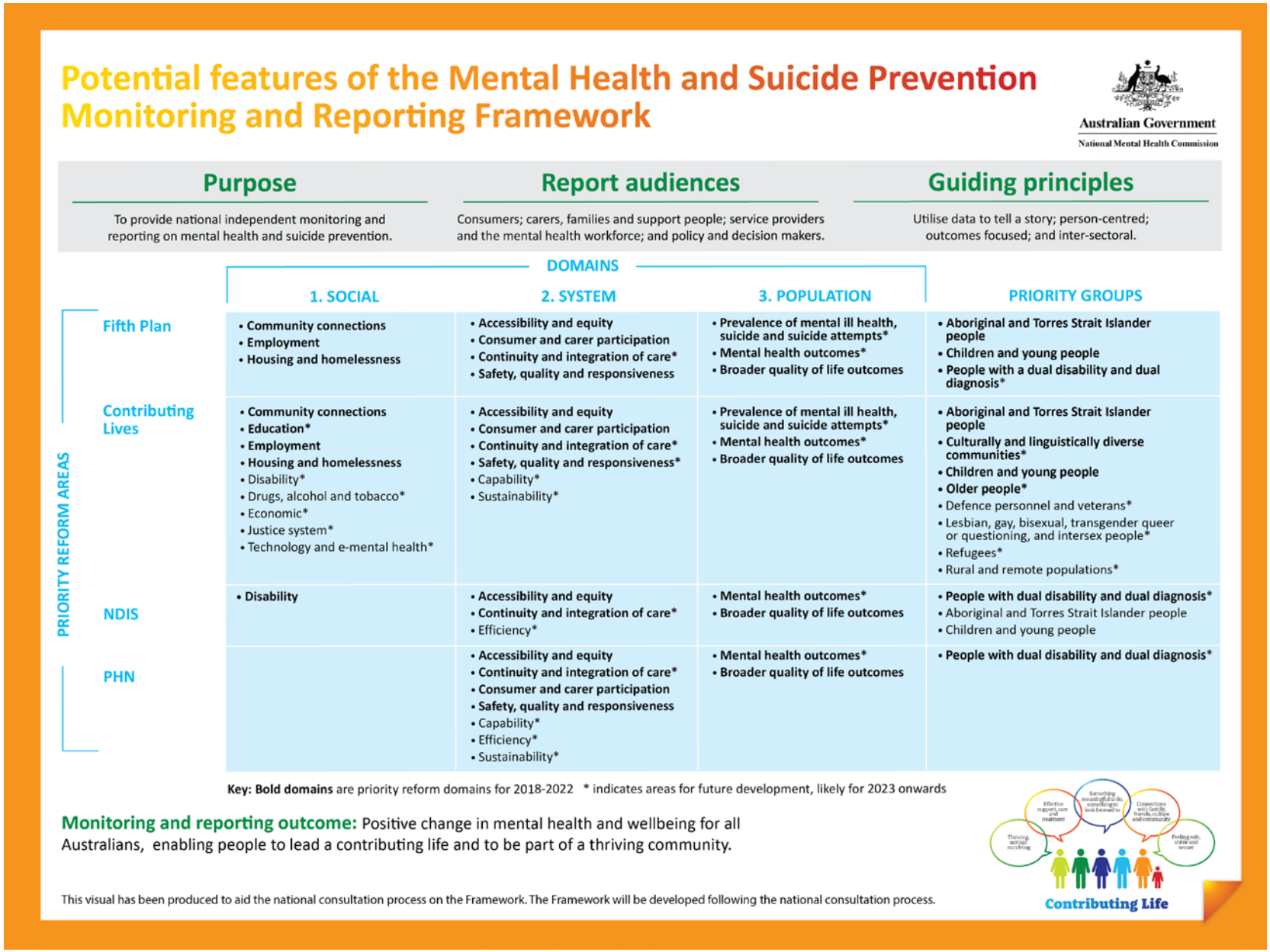
- The **purpose** describes what the Commission aims to achieve through the Framework.
- The **reporting audiences** describe key audiences for the Commission's monitoring and reporting.
- The **guiding principles** describe the manner in which the Commission proposes to monitor and report in order to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

The proposed domains align to four reform priorities:

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

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

Figure 3: Overview of potential components of the Framework



6 Social domains

Social domains include conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.[2]

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

Table 2: Social domains

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

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

Additional domains

6. **Drugs, alcohol and tobacco: Minimising the use of harmful substances**

Excessive consumption of alcohol, use of tobacco, illicit drugs, and/or misuse of pharmaceutical drugs can impact negatively on a person's health. Substance abuse can further result in increased risk taking behaviours, along with financial, health and interpersonal stressors that can negatively impact on a person's ability to live a contributing life.

7. **Economic: Having the means to live a contributing life**

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

8. **Justice system: A justice system that supports positive mental health and wellbeing**

Criminal activity and exposure to the criminal justice system, particularly through detention, is linked to the development and/or exacerbation of mental ill health. Similarly, in some cases mental ill health can increase risk of criminal activity. Victims of crime are also more at risk of mental ill health and suicidality. It is important that the justice system supports positive mental health and wellbeing.

9. **Technology and e-mental health: Connecting and supporting online**

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

7 System domains

For the purposes of the Framework, the term 'system' describes the activity of all organisations and resources focused on providing care to improve the mental health and wellbeing for people in Australia.[3] This also includes relevant organisations and resources in the broader Australian health and social services systems, given the highly interrelated nature of mental health with broader health and social determinants.

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

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

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

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

Table 3: System domains

System
Priority domains (over the next five years)
1. **Accessibility and equity:** Timely access to care for all
Accessibility and equity refers to the system's ability to provide all consumers in Australia with the supports they need, when they are needed, irrespective of factors such as income, geography and cultural background. This is important to ensure timely and proactive care for consumers. Under the Fifth Plan, the Commission will report on population access to mental health care. This domain includes: • the availability of mental health supports across different geographical regions and demographics • waiting times for consumers to access mental health supports • the proportion of consumers who have difficulty accessing mental health supports • changes to the availability of supports to people with psychosocial disabilities due to the implementation of the NDIS • the extent to which any difficulty accessing services can be attributed to a measure such a geographical location, ethnicity, gender, religion etc.
2. **Consumer and carer participation:** A system shaped by people with lived experiences
Consumer and carer participation refers to the representation of consumers and carers at all levels of the system, including policy development, service planning, delivery, evaluation and research. This domain supports a person-centred system that is shaped by people with lived experiences of mental ill health and suicidality. Under the Fifth Plan, the Commission will report on the proportion of total mental health workforce accounted for by the mental health peer workforce. This domain includes: • consumer and carer reported measures of involvement in care planning and decisions • the representation of consumers and carers in the senior governance of service provider organisations

- the engagement of consumers and carers in policy development
- the presence of consumer and carer feedback mechanisms for providers of care.

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

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

- post-discharge community care
- re-admission to hospital
- rates of follow-up after suicide attempt/self-harm.[4]

This domain includes:

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

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

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

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

This domain includes:

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

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

- the prevalence of prescription drug use
- the provision of gender specific wards.

Additional domains
5. **Capability:** A system equipped to care for consumers
Effectiveness refers to the system's core capabilities that enable high quality services and support for consumers to support overall performance of the system and ensure positive outcomes for consumers who experience mental ill health and suicidality. This domain includes: the capability levels of the mental health workforce; the performance of service provider enablers such as systems and technology; and the strength of service provider governance mechanisms (including mental health clinical governance).
6. **Efficiency:** Providing value for money for society
Efficiency refers to the system's ability to achieve desired outcomes with the most cost effective use of resources. This ensures the system extracts the maximum value from funding inputs, and is able to keep the cost of service provision low. This domain includes: technical efficiency of provision (across both hospital and community care); and the average cost of supports (across both hospital and community care).
7. **Sustainability:** A system that can meet future needs
Sustainability refers to whether the system's inputs and infrastructure are sufficient to respond to emerging needs and ensure quality services can be provided in the long term. This includes both funding inputs and workforce inputs. This domain includes: the level of funding for mental health supports; the strength of mental health workforce planning; the level of investment in workforce training; and the level of investment in mental health research (including research translation) and innovation.

8 Population domains

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

Table 4: Population domains

Population
Priority domains (over the next five years)
1. **Prevalence of diagnosable mental ill health, suicide and suicide attempts:** Building a mentally healthy population
This domain measures the number of people in Australia who have diagnosable mental ill health or experience of suicidality, as well as the population rates of suicide. Although measures of change in mental ill health prevalence are not updated it is important for the Framework to consider prevalence to understand the extent of mental ill health and suicidality in Australia. Under the Fifth Plan, the Commission will report on the following indicators: • prevalence of mental ill health

- proportion of adults with very high levels of psychological distress
- rates of suicide and self-harm.

This domain includes:

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

2. **Mental health outcomes:** Improving the mental health and wellbeing of people with lived experience

This domain measures the mental health outcomes for people in Australia who experience mental ill health or suicidality. Monitoring and reporting on this domain will be supported by the roll out of the Your Experience of Service (YES) survey, which includes a range of patient-reported experience measures (PREMs) as well as a number of patient-reported outcomes measures (PROMs).[5] Under the Fifth Plan, the Commission will report on the following indicators:

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

This domain includes:

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

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

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

- rate of drug use in people with mental ill health
- avoidable hospitalisations for physical illness in people with mental ill health
- connectedness and meaning in life
- rate of social/community/family participation amongst people with mental ill health

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

- proportion of people with mental ill health in employment
- proportion of carers of people with mental ill health in employment
- proportion of mental health consumers in suitable housing
- experience of discrimination in people with mental ill health.

This domain includes:

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

9 Priority groups

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

Table 5: Priority groups

Priority groups
Priority groups (over the next five years)
1. **Aboriginal and Torres Strait Islander People**
Aboriginal and Torres Strait Islander mental health is a national policy priority due to its marked disparity against general population mental health. On average, Aboriginal and Torres Strait Islander people have higher exposure to mental ill health risk factors such as discrimination, imprisonment and substance abuse.[6] These factors can also lead to problems of intergenerational disadvantage amongst Aboriginal and Torres Strait Islander people.
2. **Culturally and linguistically diverse communities**
Culturally and linguistically diverse (CALD) communities include people who recently migrated to Australia or whose family has done so. Migration to a new culture can often create or exacerbate mental distress, including mood disorders and anxiety.[7] Furthermore, cultural and language barriers can impede a consumer's ability to navigate the mental health system, including the ability to access and receive appropriate supports.

[6] The National Mental Health Commission. Contributing Lives, Thriving Communities. 2014.
[7] Khawaja NG et al. Characteristics of culturally and linguistically diverse mental health clients. 2013.

3. Children and young people

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

- Proportion of children developmentally vulnerable in the Australian Early Development Index.

4. Older people

Older people often face changing social determinants that can negatively impact their mental health. This includes changes to employment as they transition to retirement, accompanying changes in their economic status and potential loss of social and community connections. Furthermore, older people have an increased risk of chronic physical health issues which are a risk factor for mental ill health.

5. People with a dual disability and dual diagnosis

People living with a dual disability (co-occurring disability and mental ill health) or dual diagnosis (co-occurring drug and alcohol issues along with mental ill health) include, for example, people with an acquired brain injury (ABI) who also experience mental ill health. It can be difficult to obtain support for people living with a dual disability or dual diagnosis, as services are often provided separately for each of the co-occurring issues. Mental ill health can increase risks associated with a brain injury, for example; increased risk of social isolation, family breakdown, unemployment, aggression and risk of exploitation.[8]

Additional population groups

6. Defence personnel and veterans

Defence personnel and veterans are at a higher risk of stress disorders (including post-traumatic stress disorder), depression, anxiety and substance abuse than the general population.[9] This can be related to traumatic experiences whilst in service, physical and chronic injuries and the transition from the military into civilian life.

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

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

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

LGBTQI people have been shown to on average have poorer mental health than the general population, including a higher risk of depression, anxiety, self-harm and suicide.[10] This is often driven by factors such as violence and discrimination which can result in and exacerbate mental ill health.

8. Refugees

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

9. Rural and remote populations

Rural and remote populations have different experiences of mental ill health compared to urban areas, including higher rates of suicide and higher rates of alcohol misuse.[11] This is related to social determinants such as regional economic factors and potential for social isolation due to geographical distance. Furthermore, lower levels of service access in rural and remote areas can impact overall mental health outcomes.

10 Opportunities for the Commission to add value through analysis

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

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

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

The Commission can encourage others to address data gaps and linkage

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

[10] Leonard W et al. Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians. 2012.
[11] The Royal Australian and New Zealand College of Psychiatrists. Mental health in rural areas. Accessed 25 August 2017.

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

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

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

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

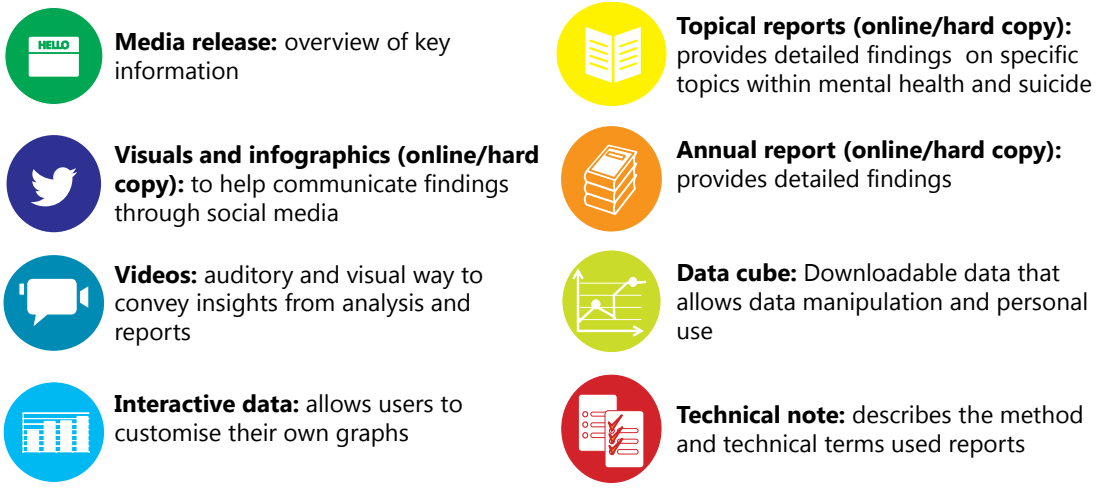
There may be opportunities for the Commission to use unique, technology-enabled data sources to support future monitoring and reporting. These data sources may include social media data and google search analytics. These potential data sources will be explored and assessed further once the draft Framework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

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

11 Flexible reporting

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

Figure 4: Potential monitoring and reporting formats



Online formats can include downloadable PDF reports, visuals, and infographics, as well as interactive annual reports hosted via a micro-site.[12] Different audiences tend to be interested in varying levels of detail. For example, the general public frequently engages best with short and sharp messaging, while academics and service providers are often interested in deeper levels of analysis and detail. All audiences tend to find interactive reports and data analytics tools appealing and audiences value being able to dip in and out of information easily. Some would find immense value in raw data sets to produce their own tailored analysis. It is important to note that a significant impact on reporting is the availability of data.

12 Consultation questions

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

1. What are the mental health monitoring and reporting priorities in your community, region or jurisdiction?
2. What information gaps are there in the current mental health and suicide monitoring and reporting landscape?

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

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

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

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