

Queensland Mental Health Commission effectiveness review

June 2016



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Abbreviations

AOD	Alcohol and Other Drugs
AW&R	Advocacy, Workforce and Research
CALD	Culturally and Linguistically Diverse
CEO	Chief Executive Officer
Commissioner	Mental Health Commissioner
DCCSDS	Department of Communities, Child Safety and Disability Services
DET	Department of Education and Training
DJAG	Department of Justice and Attorney-General
FTE	Full-time equivalents
HASC	Health and Ambulance Services Committee
HHS	Hospital and Health Service
KRA	Key Result Area
LGBTI	Lesbian, Gay, Bisexual, Transgender or Intersex
MHAODB	Mental Health Alcohol and Other Drugs Branch
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation
NMHC	National Mental Health Commission
NSW	New South Wales
NZ	New Zealand
P&A	Promotion and Awareness
PHNs	Primary Health Networks
PSC	Public Service Commission
QLD	Queensland
QAMH	Queensland Alliance for Mental Health
QHPC	Queensland Health Promotion Commission
QMHC	Queensland Mental Health Commission
QMHDAC	Queensland Mental Health and Drug Advisory Council
QPS	Queensland Police Service
RRR	Review, Research and Report
SA	South Australia
The Act	<i>Queensland Mental Health Commission Act 2013</i>
TOR	Terms of Reference
VIC	Victoria
WA	Western Australia

Summary of findings

Overall

The Queensland Mental Health Commission (QMHC), over the past three years, has played a key role with the Department of Health in positioning mental health reform across the health sector.

The QMHC's performance of its functions under *Queensland Mental Health Commission Act 2013* (the Act) has been commendable, particularly considering the challenging policy and service delivery environment. There is no doubt the QMHC has done much to advance the objects of the Act in driving ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system. The QMHC has met its legislative requirements and established a strong reputation for reform to improve services to some of Queensland's most vulnerable community members.

The QMHC's focus on evaluation driven by the voice of the customer provides an excellent blueprint for other policy-based organisations. The QMHC's Social Housing Ordinary Report¹ and the Ed-LinQ initiative² are highly praised as exemplars of evidence-based research informing policy and practice in complex and multi-faceted agendas.

In such a challenging environment, there will always be more to do. Importantly, the QMHC has positioned itself well to continue this important reform agenda. This report has identified areas where a recalibration of effort and focus will potentially make the greatest impact in what might be considered a second phase of reform.

The QMHC is encouraged to continue to build on the solid foundation it has created through establishing an evidence-base to monitor progress, listening to the voices of stakeholders and working collaboratively.

The QMHC has an opportunity to reach out even more effectively to stakeholder groups who are seeking stronger collaboration to meet their organisational goals. The QMHC is well positioned to influence changes occurring in the health context, including the introduction of the National Disability Insurance Scheme and the Primary Health Networks. These disruptions in the sector could provide key catalysts for the QMHC to increase its effectiveness by working increasingly in partnership and co-design with other government agencies to drive reform, particularly for individuals with complex needs.

There is also an opportunity for the QMHC to work closely with community organisations and government agencies to improve outcomes by engaging more strongly with frontline staff; to better advocate for the rights of individuals to have a stronger voice in their care and treatment decisions. This approach would support a more place-based approach that could reach beyond QMHC's core agenda and complement stronger partnerships with community organisations and other government agencies.

¹ The QMHC has provided details of this initiative; see Appendix 2, Key result area 2.

² The QMHC has provided details of this initiative; see Appendix 2, Key result area 3.

The review processes identified a number of suggestions from key stakeholders, which have been noted for consideration as part of the upcoming legislative review.

Review approach

The review explored the QMHC's effectiveness in terms of its legislative function under the *Queensland Mental Health Commission Act 2013*. Drawing on the views of 450 stakeholders from the client satisfaction survey (conducted by Paxton Partners) and 30 interviews and written submissions, the review analysed the QMHC based on:

- overall value and effectiveness
- strategic positioning
- key result areas: whole-of-government strategic planning, research review and reporting, promotion and awareness, and systemic governance
- customer focus
- collaboration.

In practice, the above are highly inter-connected.

The following recommendations provide guidance on continuing areas of focus to further enhance support for Queensland communities.

Recommendations

1. Continue to invest in its evaluation framework and seek to broaden the respondent base to more fully represent the views of all stakeholders (Chapter 2).
2. Evaluate the key drivers of successful reform in policy and practice arising from the Social Housing Ordinary Report and Ed-LinQ initiatives to share with other agencies, and inform the QMHC future agenda and approach (Chapters 2 and 3).
3. Develop a communication and media strategy to better position and promote its role in system reform (Chapter 3).
4. Refine its approach to stakeholder engagement so it supports agendas driven by others and leverages off their existing networks and strategies. In particular, this should focus on organisations that are seeking to work more collaboratively with the QMHC to achieve their organisational goals (Chapter 3, 4 and 6).
5. Recalibrate its priorities placing a greater focus on systemic changes to support the needs of individuals with multiple challenges with a lessened focus on whole-of-government strategic planning (Chapter 4).
6. Place an increased focus on the following activities:
 - monitoring and implementing strategic and action plans
 - supporting stronger engagement at the local community level
 - the needs of Aboriginal and Torres Strait Islander communities and individuals with multiple challenges (Chapter 4).
7. Review the whole-of-government strategic plan and other strategies to leverage off the establishment of the Primary Health Networks and the introduction of the National Disability Insurance Scheme (Chapter 4).

8. Work with service providers and the Department of Health on strategies to build the capability of the workforce to treat individuals more holistically (Chapter 4).
9. Work more closely to foster partnerships with community organisations and government agencies to shape improved policy and practices for the broader community as well as those with particular vulnerabilities - with a particular focus on the culturally and linguistically diverse community; those in the criminal justice system; remote area communities; lesbian, gay, bisexual, transgender and intersex communities; those impacted by alcohol and other drug misuse; and suicide prevention advocates (Chapter 4 and 5).
10. Work more closely with community organisations and government agencies' leadership teams to engage more directly with frontline staff to better draw on the views of consumers, families and carers—to support a stronger place-based approach and better advocate for the rights of individuals to participate in their care and treatment decisions (Chapter 5).
11. Build stronger working relationships with the Department of Health and Hospital and Health Services to leverage off existing information and systems (Chapter 6 and 7).
12. Participate in the annual whole-of-government *Working for Queensland* survey (Chapter 7).
13. Department of Health consider the issues raised by stakeholders in the upcoming legislative review of the Act (Chapter 7).

Chapter 1 – Background

The Queensland Mental Health Commission (QMHC), established on 1 July 2013 under the *Queensland Mental Health Commission Act 2013* (the Act) to drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system.

The Minister for Health and Minister for Ambulance Services is required to arrange an independent review of the performance and functions of the QMHC within three years after the commencement of Section 55 of the Act (by 30 June 2016).

In response, on 4 April 2016 the Director-General of Queensland Health requested the Public Service Commission (PSC) lead an independent review of the effectiveness of the QMHC.

Context

National level

At national and state levels, governments have a shared commitment to:

- reducing stigma and discrimination in society
- significantly reducing suicide rates
- ensuring people affected by mental health and substance abuse issues and their families have access to appropriate services and supports, stable and safe homes, and are able to participate successfully in education and employment.³

The Council of Australian Governments *The Roadmap for National Mental Health Reform 2012–2022* outlines the direction for governments to take over a 10-year period, with the aim of better targeting existing funds to where they are needed and to the right models of care.

In 2014, the National Mental Health Commission (NMHC) released the *National Review of Mental Health Services and Programmes 2014*, which highlighted the lack of integration and coordination leading to individuals navigating a ‘complex and fragmented system...a patchwork’. The national review made 25 recommendations calling for an increased focus on awareness, prevention and early intervention, and better service coordination.⁴

Australia’s approach to responding to the harms associated with alcohol and other drugs comprises three pillars of the *National Drug Strategy: reducing supply, reducing harm and reducing demand*. The draft National Drug Strategy 2016–2025 describes a nationally agreed harm minimisation approach to reducing the harm arising from alcohol, tobacco and other drug use. As well as outlining the national commitment to the harm minimisation approach, the strategy describes priority actions, groups and drug types and summarises effective demand, supply and harm reduction strategies. The strategy also includes headline indicators to monitor success.

³ Council of Australian Governments *The Roadmap for National Mental Health Reform 2012–2022*, p3.

⁴ QMHC Annual Report 2014–2015, p38.

Policy and planning at national and state levels focus on the need to establish strong partnerships between services and recognises integration of care is essential to the delivery of effective services for people with substance misuse issues and mental health problems. The National Disability Insurance Scheme (NDIS) and the formation of the Primary Health Networks (PHNs) are two key examples of this approach.

- The NDIS will progressively roll out across Queensland over a three-year period (July 2016 to June 2019). Administered by the National Disability Insurance Agency (NDIA), the NDIS will change the way disability support is funded and delivered in Queensland.
- PHNs were established in Queensland in 2015, and will be responsible for commissioning Commonwealth Government mental health funding from 2016–2017. PHNs are a key stakeholder for the QMHC and its Commonwealth funded primary health services for people with mental health and substance misuse issues.

Queensland level

A wide range of government, non-government and private sector service providers in Queensland provide mental health and substance misuse services. As part of national health reforms, Hospital and Health Services (HHSs) were established as independent statutory bodies responsible for the delivery of public health services, including mental health and alcohol and other drug (AOD) services. Under the Act, the QMHC is required to engage and consult with the Hospital and Health Boards that govern the HHSs. Section 34 requires mutual co-operation between the QMHC and relevant agencies in the exercise of their respective functions. Further, Section 35 requires the Director-General Queensland Health to take the whole-of-government strategic plan into account when negotiating service agreements under that Act to the extent the agreements relate to the delivery of mental health and substance misuse services.

As part of the national health reforms in Queensland, the Department of Health's role has changed to being the system manager, with responsibility for system leadership, system-wide direction setting, planning, purchasing, and regulatory and other responsibilities.⁵ This structural change has separated the role of funding and purchasing (the role of the system manager) from that of service delivery (by HHSs and contracted private or non-government providers). Subsequent to these reforms, AOD services were integrated with public mental health services across Queensland.

The *Queensland Mental Health Act 2016* introduces significant reforms and improvements. It also aims to improve and maintain the health and wellbeing of people living in Queensland who do not have the capacity to consent to being treated, while safeguarding their rights and ensuring care is provided in a way least restrictive of their rights and liberties. The QMHC provided submissions to the Department of Health and to the Parliamentary Committee that informed the drafting of the legislation. A number of agencies will continue to have an important role in monitoring the implementation of the legislation across the state. The QMHC has indicated it will continue to advocate for the principles of the legislation to be embedded in implementation.

⁵ Hunter Review, page 7

Emerging issues

On 16 September 2015, the Legislative Assembly referred an inquiry into the establishment of a Queensland Health Promotion Commission (QHPC) to the Health and Ambulance Services Committee (HASC) for consideration. The HASC is due to report to Parliament by 30 June 2016. It remains to be seen how the respective roles of the QMHC and the QHPC will be defined, particularly in relation to prevention, promotion and early intervention for people with mental health and substance misuse issues.

The Queensland Government commissioned the Barrett Centre Inquiry on 14 September 2015 to inquire into the decision of the previous government to close the Barrett Adolescent Centre. Parents who were opposed to the closure of the Barrett Centre lobbied the QMHC to support their position, however the QMHC was not involved in the decision to close the centre. The inquiry is due to report to the Premier of Queensland, Annastacia Palaszczuk MP by 24 June 2016.

Section 56 of the Act requires the Minister to review the effectiveness of the legislation after three years, being 30 June 2016, and table a report about its outcome in the Legislative Assembly.

Mental Health Commissions in other jurisdictions

There are Mental Health Commissions in New South Wales (NSW), Victoria (VIC), Western Australia (WA) and South Australia (SA), as well as the NMHC. New Zealand (NZ) and Canada, as well as many other international jurisdictions, also have Mental Health Commissions. Their functions and form are varied.

In Australia and NZ, only the Queensland (QLD), WA and NZ Mental Health Commissions have AOD in their remit. Furthermore, NSW has recently moved system management for alcohol and drugs out of mental health into the wider health system.

Australia's first Mental Health Commission was established in WA in March 2010 as a department of state with a Commissioner. It currently has 106 full-time equivalent (FTE) positions. As well as providing whole-of-government policy advice, the commission allocates funding for mental health services delivered by government and non-government service providers in the health portfolio—in the context of a whole-of-government strategy. The WA Mental Health Commission has a Mental Health Advisory Council that provides independent advice to the Mental Health Commissioner in relation to issues affecting people with mental health issues, their families and service providers.

The SA Mental Health Commission was established in October 2015, administratively with a budget of around \$2 million and between 6 and 10 FTEs. It monitors and provides advice on mental health services across government and brings together life experiences of clients and professional expertise to enhance the lives of people living with mental illness.

The NSW Mental Health Commission was established in July 2012 as a statutory body in the Health Minister's portfolio, headed by a Commissioner, four Deputy Commissioners (three of these are part-time) and 26 FTEs. The commission is the most similar to the QMHC of those in other jurisdictions. It had a budget of \$9.7 million in 2014–2015.

The NMHC was established as an executive agency in the Department of the Prime Minister and Cabinet. It has nine Commissioners and a Chief Executive Officer (CEO) who is also a Commissioner. The NMHC seeks to monitor progress in reform at a national level.

Queensland Mental Health Commission established

The policy rationale for separating out functions from the Department of Health to an independent statutory agency (the QMHC) was to provide greater capacity to influence and leverage reform.⁶

The functions of the QMHC are set out in Section 11 of the Act. Establishment of the QMHC was overseen by an interagency steering group headed by a Deputy Director-General of Queensland Health. In 2014-2015 the QMHC's establishment was 15 FTE with an operating budget of approximately \$8.7 million.

The Mental Health Commissioner (Commissioner) is appointed by the Governor in Council under the Act, is responsible for the management and performance of the QMHC's functions in accordance with requirements of the Act.

The Queensland Mental Health and Drug Advisory Council (QMHDAC) was established under the Act to provide advice to the QMHC on mental health or substance misuse issues on its own or at the request of the Commissioner. The QMHDAC may also make recommendations to the Commissioner relating to QMHC's functions. In September 2013, the first Chair was appointed and the full Council met in April 2014. In May 2016, the Minister for Health and Minister for Ambulance Services appointed a new chair and 11 new members.

Review framework

The PSC drafted a Terms of Reference (TOR) for the review in consultation with the Department of Health and approved by the review steering committee (Appendix 1).

The TOR outline the overall purpose of the review, as set out in the Act:

The Minister for Health and Minister for Ambulance Services must arrange an independent review of the performance by the commission of its functions within three years after the commencement of Section 55 of the Act (by 30 June 2016).

In working towards this goal, the review identified the following objective:

To confirm the QMHC is operating effectively in terms of its function, in the performance of its identified functions (as defined in Section 11 of the Act), and to satisfy the legislative requirement for a review to take place, with recommendations to the Minister by 30 June 2016.

The review was future focused to provide guidance on priorities moving forward based on the review assessment.

⁶ Explanatory notes, QMHC Bill, p7

Activities that fall outside of the scope of the review include:

- review or redesign of business processes and practices
- funding arrangement of the QMHC
- assessment of the organisational structural design of the QMHC
- suitability of the legislative framework.

However, the review has made note of information outside the specific scope of the review that may be of assistance to the forthcoming review of legislation, as defined under S56 of the Act; such as, expectations of stakeholders and the capability of the Commission to deliver its functions given its role as described under the Act.

Review design and methodology

Initial scoping process

To develop an initial understanding of current issues, the review team conducted a series of scoping interviews with key stakeholders and reviewed reports on the QMHC website.

Scoping interviews included:

- Dr Lesley van Schoubroeck, Commissioner, QMHC
- Carmel Ybarlucea, Executive Director, QMHC
- QMHDAC
- Professor Harvey Whiteford, immediate past Chair of QMHDAC
- Mark Henley, CEO, Queensland Council of Social Services
- Dr William (Bill) Kingswell, Executive Director, Mental Health Alcohol and Other Drugs Branch (MHAODB), Department of Health
- Rebecca MacBean, CEO, Queensland Network of Alcohol and other Drug Agencies
- Kris Trott, CEO, Queensland Alliance for Mental Health
- Noel Muller, CEO, Queensland Voice

The QMHC provided a range of supporting publications, including:

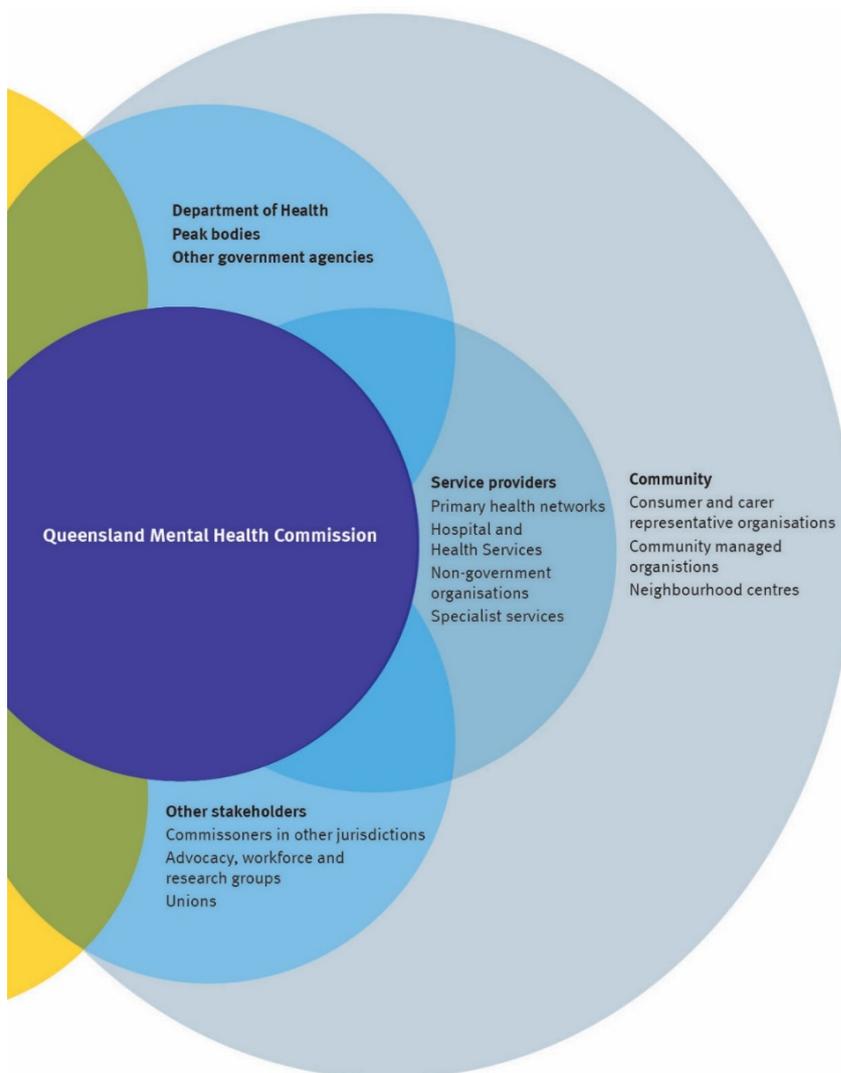
- *Evaluation methodology development final stage 2 report*, Paxton Partners (August 2015)
- *Discussion paper to inform the independent review of the QMHC* (including possible amendments to the Act to enhance effectiveness), QMHC (April 2016)
- *Establishment of a Queensland Health Promotion Commission* (submission to the Health and Ambulance Services Committee of the Queensland Parliament), QMHC (November 2015)
- Research on the effectiveness of whole-of-government policy units (Van Schoubroeck 2010)
- Overview of QMHC areas of focus (6 May 2016), provided in Appendix 2.

Analysis of this information enabled the review team to identify:

- key stakeholder groups (Figure 1)
- five specific key lines of enquiry which were explored during the review process:
 - overall value
 - strategic positioning;
 - Key result area (KRAs):
 - whole-of-government strategic planning,
 - Review, research and report (RRR);
 - Promotion and awareness (P&A); and
 - systemic governance;
 - customer focus; and
 - collaboration.

It is noted the QMHC's systemic governance KRA does not directly align to the definition used for this review, with the review interpreting this KRA as the QMHC's obligation to support individuals with multifaceted and complex needs.

Figure 1: QMHC key stakeholder groups



Information gathering approach

The review team ensured all stakeholders were provided with an opportunity for input into the review process. This was particularly important given the focus in the Act was on working in partnership with stakeholders to achieve outcomes. The review team took a tiered approach to data capture (Figure 2) providing both the breadth of perspective required and sufficient depth to inform recommendations on all of the QMHC's functions under the Act. The source of data points is summarised in Table 1.

Figure 2: Sources of stakeholder engagement

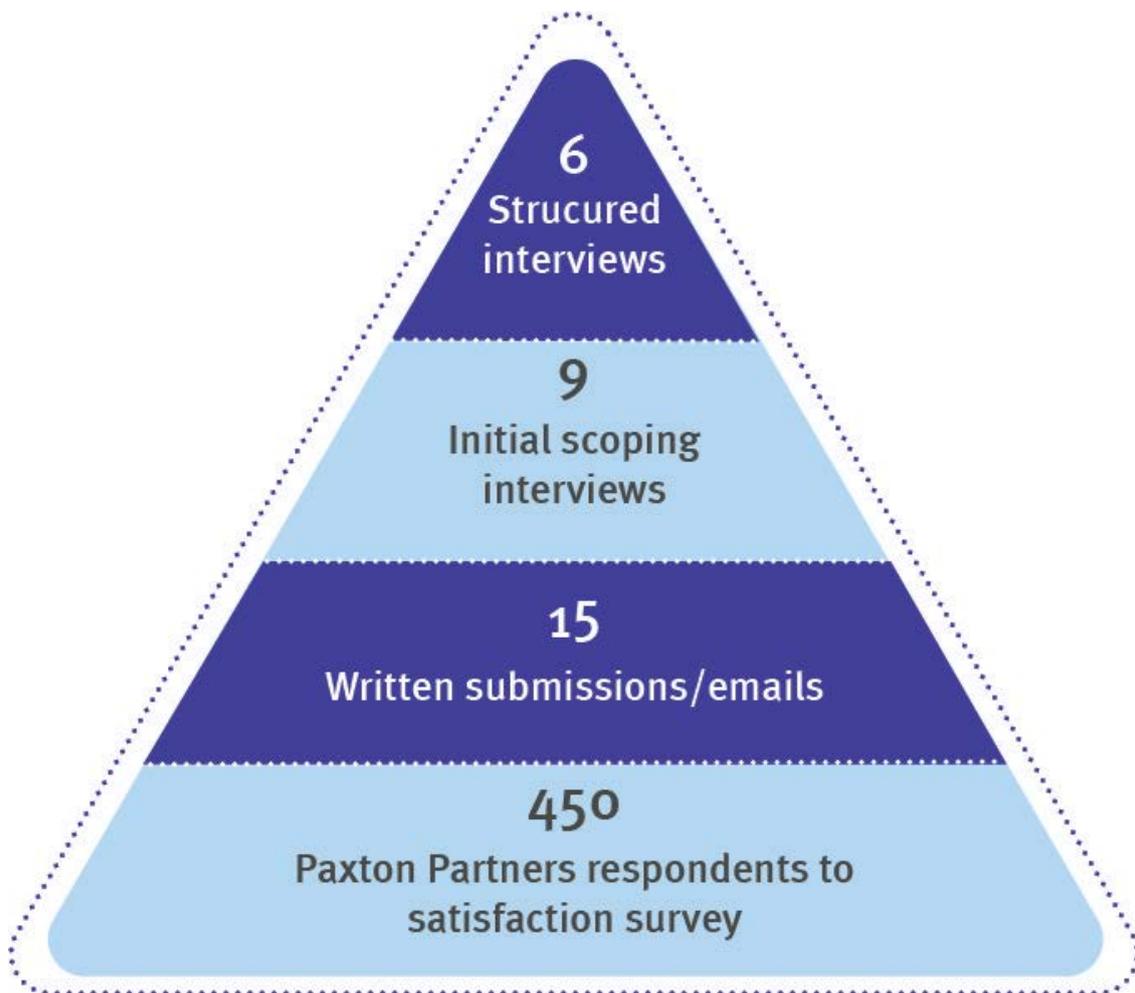


Table 1: Sources of data points

Stakeholder groups	Initial interview	Structured interview	Written submission	Email submission
QMHC				
Commissioner	1	1	1	
Employees	1	2		2
QMHDAC	2	1		
Department of Health, peak bodies, other government agencies				
Department of Health	1		1	
Peak bodies	3	1	1	
Government agencies and QMHC action plan agencies			2	1
Service providers				
HHSs			1	
Specialists services			1	
Community				
Community managed organisations	1	1	1	
Advocacy, workforce and research groups				
Advocacy, workforce and research groups			2	
Unions				
Union			1	
Other stakeholders				
State government equivalents			1 (comparison table)	
Total data points	9	6	12	3

Structured interviews

Six structured interviews were conducted with:

- QMHC Commissioner
- QMHC executive team (two officers)
- QMHC staff (eight officers)
- QMHDAC (three members)
- Association of relatives and friends of the mentally ill (three employees)
- Queensland Council of Social Services (one member).

Structured interviewees responded to questions that aligned to the written submission topics most relevant to them. They were also asked to vote on how the QMHC currently allocates its resources against the four KRAs, and where should this energy be in three years' time. We gave respondents 10 votes to allocate for both rounds.

The review team compared the voting process results with the Paxton Partners survey results on the satisfaction with each of the KRAs (refer to Chapter 4).

Written submissions

The review team sent an invitation to 108 organisations and individuals on 16 May 2016 to provide written submissions. Refer to Appendix 3 for the stakeholders identified and the engagement strategy taken. Staff had the opportunity to submit anonymous submissions to the PSC. Refer to Appendix 4 for the written submission template.

Commissioners in other jurisdictions commented on a table of interjurisdictional comparisons. The Chair, North West Hospital and Health Board in his capacity as Chair of the Hospital and Health Board Forum was invited to provide a submission.

The review team received 15 written submissions/emails.

Paxton Partners annual stakeholder survey

The review leveraged the QMHC's annual survey of stakeholders—established in its first year of operation—to monitor and guide performance. The survey supports the QMHC evaluation framework, which seeks to monitor perceptions of the QMHC's enablers, partnerships, profile, KRAs and collective impact. Stakeholders are identified as those included in the QMHC's stakeholder database and social media followers. For the purposes of this review, the PSC sought additional responses from a broader range of stakeholders.

With the support of the Commissioner, the review team worked with the annual survey provider—Paxton Partners—on the 2016 survey frame to maximise the alignment to the review's lines of enquiry, adding a small number of additional items and demographic questions. The new items:

- enabled individual stakeholders to self-assess the maturity of their collaboration⁷ with the QMHC, rather than an overall assessment provided in previous reports:

Please select the statement that best describes the level of collaboration between your organisation and the QMHC (no collaboration, networking, co-operating/co-ordinating, collaborating).

The current level of collaboration between my organisation and the QMHC is sufficient to achieve my organisation's existing strategic goals (agree/disagree).

Collaboration with the QMHC will be essential to achieving my organisation's future strategic goals my organisation's existing strategic goals (agree/disagree).

⁷ Based on Himmelman, A. (2001) On collations and the transformation of power relations: collaborative betterment and collaborative empowerment. *American Journal of Community Psychology*, 29, 277–284

- included an additional item on systemic governance:

The work of the QMHC has improved co-ordination of services for people with multiple concurrent issues (e.g. mental health, substance misuse, disability, chronic disease, homelessness and/or involvement with the criminal justice system).

- included additional demographics to identify the department of employment for state government employees.

The promotion of the survey was included in the review team's invitation for written submissions to ensure canvassing of a broad range of views. Refer to Appendix 5 for a summary profile of survey respondents, and Appendix 6 for the full Paxton Partners Review Report.

Information gathering constraints

The review team encountered a number of limitations, such as the:

- small number of written responses and lack of availability of consumer groups to participate in structured interviews due to project timeframes
- reduced number of survey responses as the survey was only available for two weeks (as at 25 May) rather than its usual four weeks, resulting in a reduced sample size from a potential 849 to 450 respondents
- use of a different survey methodology in 2016, meaning the review could not as confidently compare trends over the past three years.

These limitations are not seen as adversely affecting the analysis or recommendations of the review.

Chapter 2 – Overall value and effectiveness

Legislative requirement

Under Section 4 of the Act, the QMHC is required to drive ongoing reform towards a more integrated, evidence-based, recovery oriented, mental health and substance misuse system.

QMHC agenda

Given the range of stakeholders across the QMHC agenda, it is difficult for many to separate the role of the QMHC from the Department of Health in driving reform and change. This challenge is appreciated by the QMHC, in a submission to this review, the Commissioner asserts the success of the QMHC must be judged by its contribution to better mental health and wellbeing for Queenslanders rather than by improvements in mental health and wellbeing per se.

The Department of Health also readily acknowledges this complexity:

Within Queensland Health, the QMHC's strategic priorities of suicide prevention and least restrictive practice has translated to the service provision level, however these are also the priorities of Queensland Health. Therefore, it is difficult to separate the role of the QMHC and Queensland Health in driving change. Both complement each other and the QMHC appears to have had some success in placing the strategic priorities in the mind of the Minister and Hospital and Health Boards. While Queensland Health's focus is on supporting reform within the HHSs. (Department of Health)

The QMHC's agenda is well summarised in the following QMHDAC comment:

Mental Health Commissions around Australia, and the QMHC, have been established in part, due to frustrations with the lack of progress in mental health reform and the desire to have a body, independent of the bureaucrats within government and the influence of party politics and the election cycle. (QMHDAC)

There were differing views as to whether or not Queensland should follow the lead of WA and transfer purchasing powers for mental health clinical services from the Department of Health to the QMHC.

Key Paxton Partners survey item

Overall, there is positive reform underway (agree/disagree)

Achievements

To gauge its effectiveness, the QMHC has delivered a strong evidence-based evaluation framework that monitors the views of a diverse and complex stakeholder group. The framework provides baseline information and supports the QMHC to refine strategies based on stakeholder satisfaction and feedback.

Further, the QMHC's whole-of-government strategic plan⁸ includes a set of key outcomes, developed to international standards against which the collective performance of mental health systems can be assessed.

The QMHC has achieved significant success in driving reform with increasing levels of satisfaction from stakeholders, particularly with service providers, non-government organisations (NGO) and the Department of Health. Over the past three years, an increasing proportion of Paxton Partners⁹ respondents have indicated in overall terms, positive reform is underway, increasing from 49 per cent positive to 62 per cent (Paxton: Figure 9), with particularly strong results from NGOs (79 per cent) and service providers (74 per cent) (Paxton: Figure 10). This is a significant achievement for the QMHC that has only been in operation for three years.

The housing (89 per cent) and employment (85 per cent) sectors were the most positive (Paxton: Figure 12), with the Department of Health (62 per cent) the most positive of government employees (Paxton: Figure 11).

A supportive comment from staff reflects the overall value of the QMHC:

Good focus on system reform, maintained focus on high order aspects of the system, not operationally focussed. (Staff)

There has recently been significant engagement with the Queensland Police Service (QPS), through strategic conversations¹⁰ between the QMHC, QPS, Department of Health, consumers and front line QPS officers.

Future directions

Recognising that the QMHC is now established, the QMHC stakeholders are identifying strategic issues worthy of future attention:

There is opportunity for the QMHC, in its role as a statutory body, to add value...by more fully focussing its efforts on broader inter-sectoral issues, ensuring the voice of vulnerable population groups, directing activity to shared and underlying determinants of mental illness and substance misuse, and avoiding a siloed approach. (Department of Health)

The QMHC has had limited effect to date on mental health service delivery reform; there has been minimal changes or improvements to mental health service delivery since the introduction of the Commission. (Advocacy, Workforce and Research [AW&R] group)

In terms of sectors, Paxton Partners respondents indicated QMHC has more work to do in the child and family (34 per cent negative), criminal (30 per cent negative), business and private sectors (23 per cent negative) (Paxton: Figure 12).

There is an opportunity for increased engagement with the QPS. Although 46 per cent of respondents were positive, almost half of QPS respondents were unable to comment on the question, suggesting they may be less aware of reforms in the system (Paxton: Figure 11).

⁸ The QMHC has provided details of its areas of focus, see Appendix 2.

⁹ All Paxton Partners results are provided in Appendix 6.

¹⁰ The QMHC has provided details of its areas of focus, see Appendix 2, KRA 1.

Conclusion

To support QMHC to gauge its effectiveness, it has delivered a strong evidence-based evaluation framework. In a complex health sector, the QMHC's key value proposition to its stakeholders lies in its unique ability to navigate and position its agenda across community organisations and Queensland public sector agencies to support ongoing reform.

To build further sector wide reform, QMHC is encouraged to provide clear evidence of how consultation has resulted in actions at the service delivery level; and continue to seek stronger relationships with the QPS, HHSs, Department of Justice and Attorney-General (DJAG); and child and family, justice and business and private sectors.

Recommendations

- Continue to invest in its evaluation framework and seek to broaden the respondent base to more fully represent the views of all stakeholders.
- Evaluate the key drivers of successful reform in policy and practice arising from the Social Housing Ordinary Report and Ed-LinQ initiatives to share with other agencies, and inform the QMHC future agenda and approach.

Chapter 3 – Strategic positioning

Legislative requirement

One of the guiding principles in the Act is that an effective mental health and substance misuse system is the shared responsibility of the government and non-government sectors, and it requires a coordinated and integrated approach, as well as a commitment to communication and collaboration.

Section 11(2) of the Act provides that the QMHC, in exercising its functions, should:

- focus on systemic mental health and substance misuse issues; and
- take into account contemporary evidence and relevant policy and strategic frameworks.

QMHC agenda

In the first three years of its operation, the QMHC has focused on building the necessary relationships and ‘filling the gaps’ in the system to build a foundation for its operation. At the same time, it has been required to make its business systems operational. This approach is clearly articulated by the Commissioner:

The QMHC has been involved in setting broader government policy for good mental health and wellbeing, including providing guidance for agencies. Sometimes this involves the QMHC finding a gap in the system which it then focuses on to bring about make reform. To some extent and in some areas, the way an agency engages can inform the ‘how’ of performing our functions. For example, do we facilitate or does the agency take the lead, do we contract or a combination of approaches to get the best result?

The evaluation framework developed by Paxton Partners for the QMHC uses the Theory of Change¹¹ as a reference point that supports the QMHC’s strategic positioning. Underpinning the Theory of Change is the concept that the role of the QMHC is one of a ‘backbone organisation’ in supporting multiple areas of work with multiple stakeholders that are directed at the common goal of realising improved mental wellbeing and reduced harm from AOD misuse.

Key Paxton Partners survey item

I view the QMHC as an important driver of reform of the mental health, drug and alcohol system in Queensland (agree/disagree)

Achievements

The QMHC is seen to have been consistently driving reform over the past three years, with approximately three quarters of Paxton Partners¹² respondents consistently seeing the QMHC as an important driver of reform (Paxton: Figure 14). Advocacy/peak body employees or representatives are the most positive with 87 per cent agreeing (Paxton:

¹¹ Paxton Partners June 2016 Interim Report – Appendix A – QMHC Evaluation Logic Model

¹² All Paxton Partners results are provided in Appendix 6.

Figure 15). Notably key community groups were very positive (i.e. persons with lived experience 78 per cent, family member of persons with lived experience 80 per cent, care giver of a person with lived experience 81 per cent positive) (Paxton: Figure 15).

The support for QMHC is well articulated in the following comments:

Conversations facilitated by QHMC have focused on innovation and improving service delivery models. This work should continue. (Peak body)

QMHC has performed well in this space through outreach, discussion papers, forums, newsletters and ongoing promotion. The QMHC has engaged a wide range of stakeholders, who have been given the opportunity to provide input to the QMHC's work. (Unions)

An example of the QMHC's role is seen in how it actively contributed to the changes in the Mental Health Act, community stakeholders used the QMHC website and workshops to actively promulgate three submissions. (AW&R group)

The Commissioner also cites their role in the review of the *Mental Health Act (2000)* as a good example of where the QMHC played a change agent role, while its advice was informed by stakeholder experience. The QMHC also enabled and empowered others to make their own submissions.

The Commissioner also refers to their role in the NDIS. The QMHC led and built a partnership with Queensland Alliance for Mental Health (QAMH) who were empowered to take leadership of the mental health/NDIS agenda. The QMHC and QAMH set up a strategic discussion between NDIA, the Minister's office, Department of Health, and Department of Communities, Child Safety and Disability Services (DCCSDS). The strategic discussion came up with a governance solution role, not based on command and control, creating a different 'how' that will be fit-for-purpose. Peak bodies endorsed the positive nature of this approach.

For a small organisation, this initial strategy has supported capability building across the sector and is more sustainable than a centrally driven controlling approach. The strong support from key advocacy/peak bodies and key community groups reflects the focus of the QMHC in engaging well with many key stakeholders.

Future directions

Stakeholders see this agenda as an area of continuous improvement for the QMHC (Government agencies). QPS employees are the least aware of the QMHC's role in reform, with 34 per cent neither agree or disagree (Paxton: Figure 16). The Department of Health was more positive compared to HHS employees with 71 per cent and 63 per cent (respectively) positive scores. This suggests an opportunity for improved engagement at HHS and frontline service provision levels (Paxton: Figure 16).

Two strong needs have been identified:

- Culturally and linguistically diverse (CALD) perspective (Specialist services)—stated there has been no strategic positioning that has impacted at a service provision level, and they are not aware of any initiatives that have facilitated greater integration between government, non-government and the private sectors

- Department of Health—felt it was unclear how the QMHC’s work has translated down to service provision level.

Suggestions for improvement from stakeholders were noted:

- QMHC being clearer of where it adds value, being more ready to ‘hand over’ agendas rather than staying too long in the supporting and driving reform and less on reports. (Staff)
- Better using existing networks of peak bodies. (Peak body)
- Developing a media and communication strategy aimed at the mental health sector and the broader community, and more effectively using social media and engage in regular Parliamentary or Ministerial forums. (Peak body)
- Improvements in the QMHC website to highlight the contribution from consultation and to be more user-friendly. (Department of Health)

There is clear appetite for greater use of existing networks:

The QMHC does not appear to spend sufficient time scoping what is already available and partners’ readiness to support service reform before publishing documents aimed at service reform. For example, reform which is aimed at public mental health alcohol and other drugs services requires a partnership between the QMHC, the Department of Health and the HHSs. There must be a clear triangle of communication and sufficient planning to ensure that the timing is optimal to support service change. (Department of Health)

The focus and flurry to produce does not show authenticity of intent to deepen the relationship. There is no effort put to building on existing relationships lead by others, only puts energy where QMHC is driving or owning the agenda, therefore does not leverage off the existing energy of others. (Service provider)

There is broad acknowledgment the QMHC has the opportunity to better leverage existing systems and networks. Such collaboration would assist the QMHC to develop more mature partnerships that facilitate communication and planning to ensure real changes are realised. This would assist QMHC to more effectively address social determinants such as employment, accommodation and prevention, drug supply and harm reduction.

Conclusion

In the first three years of its operation, the QMHC has focused on building the necessary relationships and ‘filling the gaps’ in the system to build a foundation for its operation. The Theory of Change used by the QMHC provides a clear vision of the QMHC as a ‘backbone organisation’ within the broader health system.

There are several examples of where the QMHC has worked constructively in partnership with stakeholder groups to support them to influence and shape outcomes.

However, to increase involvement in agendas that will have high impact on its stakeholders, QMHC is encouraged to refocus its approach to include agendas not necessarily driven by the QMHC. This approach would provide an opportunity for QMHC to leverage off the existing networks of peak bodies and government agencies, and build stronger partnerships with a broader range of organisations including the QPS and HHS service delivery employees. There is also a perceived need for greater focus on the CALD community.

This change in focus would benefit from more effective communication and media strategies supporting the QMHC to promote its role in system reform.

Recommendations

- Evaluate the key drivers of successful reform in policy and practice arising from the Social Housing Ordinary Report and Ed-LinQ initiatives to share with other agencies, and inform the QMHC future agenda and approach.
- Develop a communication and media strategy to better position and promote its role in system reform.
- Refine its approach to stakeholder engagement so that it supports agendas driven by others and leverages off their existing networks and strategies. In particular, this should focus on organisations that are seeking to work more collaboratively with the QMHC to achieve their organisational goals.

Chapter 4 – Key result areas

The performance framework designed by the QMHC includes four KRAs¹³, which aim to cover the functions of the QMHC under the Act. The KRAs are:

- whole-of-government strategic planning
- research, review and reporting (RRR)
- promotion and awareness (P&A)
- systemic governance.¹⁴

KRA priorities

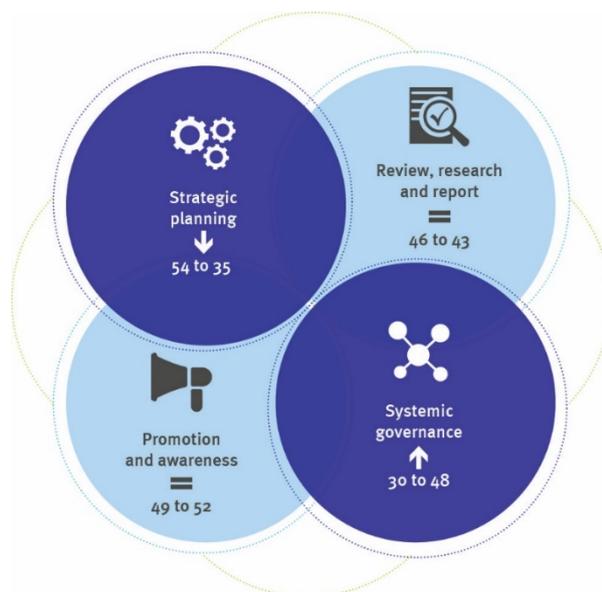
Participants in the structured interviews said the QMHC should refocus its resources and energy away from strategic planning to provide more of a focus on systemic governance over the next few years (Figure 2).

The QMHC's executive management team represented an alternate view, where they thought the current balance between the KRAs was correct. An NGO provided another alternate view that required a move of resources from RRR to more effort in P&A, which is understandable as a client-facing group would want a more applied approach to service delivery.

This recalibration of focus is articulated in the following comment:

Where I feel the Commission has potentially been constrained...is in the driving and following-up of reform. Reform is a living, breathing thing, not just a report, no matter how well consulted, researched and crafted. (Staff)

Figure 3: Relative priority of KRAs moving forwards



¹³ The QMHC has provided details of its areas of focus, see Appendix 2.

¹⁴ The review's definition of systemic governance is different to that of the QMHC. The review's definition focuses more directly on the QMHC's role in supporting individuals with complex needs.

The Paxton Partners¹⁵ survey helps to unpack this view. The two highest performing KRAs overall are RRR (64 per cent positive) and P&A (54 per cent positive). In comparison, the two lowest performing KRAs are strategic planning (36 to 52 per cent positive) and systemic governance (36 per cent positive) (Paxton Figure 19).

Future directions

The QMHC has initially focused on its role in the whole-of-government strategic planning function, which is an understandable and logical starting point, given the emphasis on the strategic planning function under the Act. The whole-of-government strategic plan and the process of developing the plan has been an important vehicle for stakeholder engagement, and a means of establishing the value proposition of the QMHC across a range of stakeholders. Naturally, this work will remain important to the QMHC as the plan evolves and matures, with outcomes evaluated over time.

Stakeholders are looking for a recalibration of priorities with a greater focus on systemic changes and service delivery reform, particularly for individuals with multiple challenges. The QMHC RRR and P&A activities are the KRAs most positively viewed by Paxton Partners survey respondents and are areas for continued focus.

4.1 Strategic planning

Legislative requirement

Section 11 of the Act requires the QMHC to prepare a whole-of-government strategic plan for approval by the Minister. Part 3 of the Act provides that the QMHC must:

- consult with relevant persons and agencies in preparing the plan;
- facilitate the implementation of the plan; and
- monitor and report to the Minister on its implementation.

Section 7 also requires the strategic plan to include strategies for supporting and promoting the:

- mental health and wellbeing of the community
- prevention of, and early intervention in relation to mental health and substance misuse
- general health and wellbeing of relevant persons; and enhancing community awareness and understanding about mental health and substance misuse issues (including reducing stigma and discrimination).

¹⁵ All Paxton Partners results are provided in Appendix 6.

QMHC agenda

The *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019* seeks to improve mental health and limit harm associated with substance misuse. The QMHC prepared this whole-of-government strategic plan within its first year of operation and following endorsement by government, launched in October 2014.

Key Paxton Partners survey items

The strategic plan has influenced activities and decisions made within my organisation (agree/disagree)

The shared commitments to action described in the strategic plan are appropriate and comprehensive (agree/disagree)

Achievements

The QMHC has fulfilled the legislative requirement under the Act to produce a whole-of-government strategic plan for mental health and substance misuse. The QMHC developed the whole-of-government strategic plan following extensive consultation with stakeholders. QMHC also engaged key stakeholders in the development of action plans¹⁶ to drive implementation of specific initiatives by relevant government agencies linked to the whole-of-government strategic plan.

The majority of Paxton Partners¹⁷ respondents (51 per cent) agreed the shared commitment to action described in the strategic plan was appropriate and comprehensive, with 37 per cent unable to comment (Paxton: Figure 39). Advocacy/peak body employees or representatives (60 per cent), service providers or their representatives (58 per cent) were the most supportive of the shared commitments to action (Paxton: Figure 40). The employment sector (67 per cent) was the most positive, followed by the child and family (65 per cent) and the drug and alcohol (59 per cent) sectors (Paxton: Figure 42). In regards to government agencies, the HHSs (62 per cent) were the most positive, followed by the Department of Health (58 per cent) (Paxton: Figure 41).

In terms of target population views on whether the shared commitments to action are appropriate or comprehensive, respondents identifying as Lesbian, Gay, Bisexual, Transgender or Intersex (LGBTI) (60 per cent) were the most positive (Paxton: Figure 43). Views on whether the strategic plan had influenced activities and decisions made within their organisation, showed Paxton Partners respondents with a disability were the most positive (41 per cent) (Paxton: Figure 49).

Key examples of success were provided by stakeholders:

- the *Early Action Plan*, the QMHC has identified priority areas for continued and future focus. (Government agency)

¹⁶ The QMHC has provided details of its areas of focus, see Appendix 2.

¹⁷ All Paxton Partners results are provided in Appendix 6.

- the *Queensland Mental Health Promotion, Prevention and Early Intervention Action Plan 2015–2017*¹⁸ has benefits in terms of the strategic direction of Mental Health Services in the state. (Peak body)
- a government agency commented it was working in partnership with the QMHC to conduct a state wide consultation process to develop the Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Action Plan.¹⁹

These achievements in stakeholder comments:

QMHC is providing an excellent and essential service that is developing nicely and has provided a focus on issues that had previously been neglected. (Peak body)

We greatly value the opportunities the QMHC has provided by including the (Advocacy group) in the action planning processes. This provides the (Advocacy group) the opportunity to focus on the wellbeing of children and young people and improve collaboration and capacity within the sector.

As a new organisation, only three years old, the (government agency) fully understands the challenges for the QMHC in establishing a new organisation, and creating an identity to improve mental health in Queensland via a policy response. In this respect the QMHC has done an excellent job and its strategic and action plans clearly outline its vision and direction.

The QMHC has put out a strategic plan that drives AOD and mental health together. (Peak body)

Future directions

To further facilitate the implementation of the whole-of-government strategic and action plans, QMHC is encouraged to continue the strategic conversations with the QPS and actively engage with the criminal justice sector. Paxton Partners respondents from the justice sector (26 per cent) (Paxton: Figure 42) were the least positive about the appropriateness and comprehensive nature of shared commitments to actions described in the strategic plan, noting the QPS were only 29 per cent positive (Paxton: Figure 41).

QMHC is encouraged to focus more strongly on engaging with members of the community with complex needs. Paxton Partners respondents who were experiencing both mental health and substance misuse issues were the least positive (28 per cent) and almost half (48 per cent) were unable to comment about shared commitments to actions (Paxton: Figure 43).

It would appear the QMHC has been more successful in producing appropriate and comprehensive plans than in influencing activities and decisions within organisations. Paxton Partners respondents were less positive overall as to whether the strategic plan had influenced activities and decisions within the respondent's organisation, with 36 per cent positive, 38 per cent unable to comment and 27 per cent disagreeing (Paxton:

¹⁸ Further details of this partnership are provided in Appendix 2, Key result area 3

¹⁹ Further details of this partnership are provided in Appendix 2, Key result area 1.

Figure 45). The QPS was the least positive government agency at 33 per cent (Paxton: Figure 47).

In particular, QMHC could work to improve the impact of the whole-of-government strategic plan on the Aboriginal and Torres Strait Islander communities. Paxton Partners respondents identifying as Aboriginal and Torres Strait Islander had the lowest positive score of 22 per cent about whether the strategic plan had influenced activities and decisions made within their organisation (Paxton: Figure 49).

Stakeholder suggestions for improvement are:

- There is a consistent view that although the QMHC has been effective in developing the whole-of-government strategic plan and action plans, it now needs to focus on driving cross sectoral implementation (Peak bodies, union, AW&R group, and the Department of Health).
- The need for QMHC to engage more at a local level and to involve both mental health and alcohol and substance misuse stakeholders (Peak body).
- The need for greater focus on the CALD agenda with an increased focus on implementation (Specialist service).

These suggestions are reflected in a key stakeholder comment:

Action plans largely reflect existing actions rather than generating new initiatives. This has made sense to get quick runs on the board, but they (QMHC) now need to move on (Government agency).

Conclusion

Feedback from stakeholders has been very positive, with particularly favourable responses from advocacy/peak body employees or representatives, the employment and health sectors, and employees from the Department of Education and Training (DET), Department of Health and HHSs.

To facilitate the successful implementation of whole-of-government strategic and action plans, further engagement with the QPS, DJAG and criminal justice sector is encouraged. This would support the QMHC to drive and monitor sectoral implementation and to engage more strongly at the local level.

With the establishment of the PHN and NDIS, the QMHC has an important opportunity to review the whole-of-government strategic plan, as mental health and AOD are key areas of priority for the PHN. As catalysts for disruption in the health sector, there is an opportunity for the QMHC to build stronger partnerships with key community organisations and government stakeholders to ensure the relevance of the whole-of-government strategic plan.

The QMHC has an opportunity to further explore approaches to increase the impact of the whole-of-government strategic plan for Aboriginal and Torres Strait Islander communities, and individuals experiencing both mental health and substance misuse issues.

4.2 Review, research and report

Legislative requirement

Under Section 11 of the Act, the QMHC's functions include review, evaluate, report and advise on:

- the mental health and substance misuse system
- other issues affecting relevant persons
- issues affecting community mental health and substance misuse, and
- research in relation to mental health and substance misuse issues.

QMHC agenda

The QMHC RRR function is charged to enhance service delivery practices and benefit consumers through providing evidence to inform policy advice and service delivery.

Key Paxton Partners survey item

The research, review and evaluation work the QMHC is commissioning helps identify and respond to current and emerging trends (agree/disagree)

Achievements

The QMHC is seen as consistently undertaking relevant review, research and evaluation work over the past three years, with over 60 per cent of all Paxton Partners²⁰ respondents providing a positive response (Paxton: Figure 20). Respondents from the housing (89 per cent), business or private (85 per cent), and employment (83 per cent) sectors were most positive (Paxton: Figure 24). The Department of Health was the most positive department (65 per cent) followed by DET (64 per cent) (Paxton: Figure 22).

Examples of success in this area were provided:

- The QMHC engaged positively across key sectors in the evaluation of the Ed-LinQ initiative, which provided recommendations for future directions, as well as raising the profile for early intervention for child and youth mental health. (Staff)
- QMHC is broadly perceived as having commissioned some useful research to inform enhancements in service delivery, for example the University of Melbourne research into least restrictive practices in acute mental health wards. (Department of Health, government agencies, AW&R groups and peak bodies)
- The Social Housing Ordinary Report underpinned changes to the Queensland Government's social housing policy, which was a positive step towards a fairer

²⁰ All Paxton Partners results are provided in Appendix 6.

system for consumers that takes into account the needs of people with complex support needs. (AW&R groups)

- QMHC has positively contributed to the projects and initiatives of other organisations, for example the research project into decision-making support and Queensland's guardianship system. (AW&R groups)

These achievements are reflected in stakeholder comments:

The social housing report highlighted the complexity of the system, and focused on recovery of the whole person. It was a practical response someone could pick up and read it, speaking to those on the ground. (Community managed organisation)

Suicide awareness...this piece of work resonated with our client group. (Community managed organisation)

QMHC has value added, the Ed-LinQ evaluation report was well received and keeps HHSs honest. (Department of Health).

Future directions

The RRR function of the QMHC remains an ongoing area of focus for stakeholders. Of all the QMHC functions, RRR is viewed the least positively by QPS employees (34 per cent) who also had the highest percentage of respondents unable to comment (66 per cent) (Paxton: Figure 22).

Stakeholder suggestions for improvement identified:

- Increased engagement with stakeholders including peak bodies (Peak bodies, Department of Health).
- Increased focus on multicultural mental health issues in Queensland (Specialist service).

Conclusion

The QMHC is meeting its legislative requirement through its research and development agenda. This is evident by the extensive range of documents to inform system reform in mental health and substance misuse. There has been consistent feedback over the past three years of the value of this agenda for stakeholders in identifying and responding to current and emerging trends.

The QMHC's Social Housing Ordinary Report and the Ed-LinQ initiative are highly praised by a wide cross-section of stakeholders as exemplars of evidence-based research informing policy and practice in complex and multi-faceted agendas. Therefore, it is not surprising the housing, employment, business or private sectors were very satisfied with the relevance of the QMHC's work in this area. There was also very strong endorsement for the relevance of this work from the Department of Health and DET.

QMHC has the opportunity to strengthen the impact of its RRR agenda through greater engagement with the QPS, peak bodies and the CALD communities.

4.3 Promotion and awareness

Legislative requirement

Section 2(c) and 11 of the Act requires the QMHC to promote prevention, early intervention and community awareness strategies in relation to mental illness and substance abuse.

The legislative functions require the QMHC to:

- support and promote strategies that prevent mental illness and substance misuse and facilitate early intervention for mental illness and substance abuse
- support and promote the general health and wellbeing of people with a mental illness and people who misuse substances, their families, carers and support persons
- support and promote social inclusion and recovery of people with a mental illness or who misuse substances
- promote community awareness and understanding about mental illness and substance misuse issues, including for the purpose of reducing stigma and discrimination.

QMHC agenda

The QMHC P&A function is charged to support and promote prevention and early intervention to enhance general health and wellbeing of people with mental illness, substance misuse, their families, carers and support persons. As such, it includes a number of relevant actions arising from the whole-of-government strategic plan as well as additional formative projects.

Key Paxton Partners survey item

The promotion and awareness work being undertaken by the QMHC is increasing community awareness and reducing stigma and discrimination (agree/disagree)

Achievements

QMHC has consistently increased awareness through its P&A function. There has been an overall positive increase of eight per cent over the past three years by Paxton Partners²¹ respondents that the QMHC's work to increase awareness and reduce stigma and discrimination is working, from 45 per cent in 2014 to 53 per cent positive in 2016 (Paxton: Figure 27). On average, all roles were positive about the work QMHC is doing with advocacy/peak bodies employees or representatives (65 per cent) with those working in NGOs (63 per cent) the most positive (Paxton: Figure 28). The employment sector (67 per cent) were the most positive, followed by the community sector (64 per cent), drug and alcohol (62 per cent), mental health and health (60 per cent respectively) sectors (Paxton: Figure 28). In terms of target populations, the

²¹ All Paxton Partners results are provided in Appendix 6.

Aboriginal and Torres Strait Islander community (61 per cent) were the most positive and the CALD community (48 per cent) were least positive. (Paxton: Figure 32)

Stakeholder examples of success in this area were:

- Queensland Mental Health Week activities and awards. (Government agencies and peak bodies)
- QMHC has worked very closely with a community group to promote greater awareness of World Suicide Prevention Day and share concerns to the Minister and Deputy Director-General regarding the apparent increase in the numbers of suicides occurring in Queensland. This generated a range of activities within the Department of Health that have a clear suicide prevention focus. (Community managed organisation)
- QMHC established a locally led pilot of an Aboriginal and Torres Strait Islander suicide prevention project in Townsville, and is developing and implementing a data and information-sharing framework to support suicide prevention. (Government agency)
- QMHC have provided a range of informative documents to drive mental health reform that are well developed and considered. (HHS)

These achievements are reflected in stakeholder comments:

QMHC put the population prevention issue on the agenda. (Staff)

(QMHC) has performed well in this space through outreach, discussion papers, forums, newsletters and ongoing promotion, and has engaged a wide range of stakeholders, who have been given the opportunity to provide input to the Commission's work. (Union)

The emphasis on shifting the focus to wellbeing and prevention, comprehensive action and a co-ordinated approach are all favourable in terms of how small organisations intend to drive forward in growth and development of their grass roots services. (Peak body)

Bringing an international expert in to facilitate a conversation with the community sector was a positive initiative for the QMHC, as it brought about broader thinking. These initiatives are useful and I would encourage the QMHC to continue this so as to be thinking broader about the outcomes of these conversations and interventions. (Peak body)

Future directions

While the P&A activities of the QMHC were recognised for good work, there are still gaps to be addressed. The justice sector was the least positive at 30 per cent, with another 40 per cent unable to comment (Paxton: Figure 31). For government agencies, interestingly the lowest level of confidence was expressed by the QPS at 34 per cent with 59 per cent unable to comment (Paxton: Figure 29).

Suggestions for improvement were noted:

- Increased focus on the translation of plans into action for the CALD communities. (AW&R group)

- Community stigma does not appear to receive sufficient attention in the promotion, prevention and *Early Intervention Priority and Early Action Plan*. (Department of Health)
- QMHC seek a higher public profile that addresses the general level of discrimination and stigma across Queensland communities and work to clarify the role of Department of Health in funding programs in the area of promotion and prevention as a major barrier. (Peak bodies, government agency)

These suggestions are reflected in a key stakeholder comment:

*The focus needs to be placed on prevention, education and rehabilitation.
(Peak body)*

Conclusion

The QMHC has demonstrated, through publications, initiatives, and engagement with key stakeholders, that it is meeting the legislative requirement in relation to its P&A agenda.

Feedback from stakeholders confirms the QMHC's P&A agenda is generally increasing community awareness and decreasing stigma and discrimination, with advocacy/peak body employees and NGOs the most positive. There was general agreement across a broad range of sectors about the positive impact of this work, in particular the Aboriginal and Torres Strait Islander community.

There is an opportunity for QMHC to heighten the impact of the P&A agenda through an increased:

- public profile on prevention, to further reduce ignorance and community stigma across Queensland communities
- focus on translating plans into action for the CALD community
- engagement with the QPS and DJAG to strengthen the impact of the P&A agenda across the criminal justice sector
- role clarity on program funding for P&A with the Department of Health to address ignorance and stigma in Queensland communities.

4.4 Systemic governance

Legislative requirement

In exercising its functions, Section 11(2)(b) of the Act requires the QMHC to take into account:

- comorbid issues including disability, chronic disease and homelessness; and
- people with mental health and substance misuse issues in the criminal justice system.

QMHC agenda

The QMHC seeks to take into account individuals with multi-faceted and complex needs such as disability, chronic disease, homelessness, mental health and alcohol and substance misuse, and involvement with the criminal justice system.

Key Paxton Partners survey item

The work of the QMHC has improved co-ordination of services for people with multiple concurrent issues (e.g. mental health, substance misuse, disability, chronic disease, homelessness, and/or involvement with the criminal justice system (agree/disagree)

Achievements

The Social Housing Ordinary Report is a strong example of how the QMHC has taken into account individuals with multi-faceted and complex needs and made a difference at the system level. This report impacted on both policy and practice which was reflected by Paxton Partners²² respondents, with 67 per cent of those in the employment sector and 53 per cent in the housing sector were most positive that the QMHC had improved the coordination of services for people with multiple concurrent issues (Paxton: Figure 36).

This achievement is highlighted in this stakeholder comment:

The Social Housing Ordinary Report underpinned changes to the Queensland Government's social housing policy, which was a positive step towards a fairer system for people with impaired decision-making capacity. (AW&R group)

Future directions

Overall, the QMHC has commenced making systemic change; yet key stakeholders (service providers, specialist services and peak bodies) are seeking greater engagement and involvement.

Notably, 49 per cent of health and 50 per cent of justice sector Paxton Partners respondents were not able to comment on how the QMHC improved coordination of services for people with multiple concurrent issues (Paxton: Figure 36). Overall, only 36 per cent of respondents were positive, with a large percentage (41 per cent) unable to comment (Paxton: Figure 34). In terms of government agencies, DET (43 per cent) was the most positive and HHSs (26 per cent) were the least positive (Paxton: Figure 35).

A number of key target groups for this agenda also had mixed views. Respondents from the Aboriginal and Torres Strait Islander, CALD, and disability communities; and persons experiencing both mental health difficulties and issues relating to substance use were 40–43 per cent positive (Paxton: Figure 37). The LGBTI community were the least positive (24 per cent) with 59 per cent unable to comment (Paxton: Figure 37).

Of particular note, is the impact of geography on views with Paxton Partners respondents living in a major city (37 per cent) or inner regional Australia (39 per cent) more positive than those in outer regional Australia (30 per cent) (Paxton: Figure 38).

To affect more change in the health system, there is a need for greater focus on individuals with multi-faceted and complex needs, including:

- a need to share evidence of progress (Peak body)

²² Paxton Partners full results are provided in Appendix 6.

- recognising that AOD misuse is bigger than a health issue, not just a criminal issue, creates multiple morbidities, physical, dental, chronic disease such as cardio-vascular or emphysema, poor nutrition. They suggest that QMHC needs separate yet connected policy expertise beyond the QMHC. (Peak body)
- people with dual disability do not appear to be well represented in the QMHC's priorities (Department of Health, specialist service)
- other sectors like homelessness, housing etc. (Peak body)
- the availability of and access to an appropriately qualified specialist mental health workforce inclusive of expertise regarding persons with a 'dual diagnosis' (Union).

These suggestions are reflected in stakeholder comments:

The QMHC needs to know who their customers are to ensure that the attention is not exclusively on the 'squeaky wheel', or those sections of the community who are well represented by advocacy groups. Whilst it is appreciated that the QMHC's focus is on those with multi-faceted and complex needs, to promote early intervention and prevent increasing vulnerability, attention needs also to be paid to those whose needs are not yet at the most complex or severe end of the spectrum. This could be done in partnership with other government departments, e.g. partnerships with DCCSDS to consider the mental health and support needs of single parent families. (Department of Health)

Keen to see QMHC partner with others to pilot new service delivery practices at the local level, taking a place based approach to overcome multi-faceted issues. The government and community response should not be doing things to people, needs to be co-designed and co-created. All the research says prevention, early intervention should be the target of the sectors energy. (Peak body)

Conclusion

A key to QMHC effectively driving reform for members of the community with multiple challenges is the degree of commitment and action taken by a wide range of government and non-government organisations and service providers. Stakeholders have mixed views as to whether the changes the QMHC are instigating is creating system change for individuals with multiple issues. Stakeholders see this as an increasing priority for the QMHC.

Organisations are seeking to engage with the QMHC to ensure ongoing systemic change. This should include a heightened focus on the criminal justice and health sectors, HHSs, and the LGBTI community, who are the least aware of the QMHC's efforts in this area.

To achieve greater traction on this complex agenda QMHC is encouraged to explore:

- co-design with stakeholders to develop greater local placed-based early detection and prevention strategies
- increased focus on vulnerable sections of society, such as the CALD community, the homeless, those with a dual diagnosis, those in the criminal justice system, and those in remote areas

- strategies to further build the capability of the health workforce to better support health workers to treat individuals entering the system more holistically
- increased policy expertise that can work through the complexities of multi-faceted and complex needs
- improved working relationships with the Department of Health and HHSs.

Recommendations

- Refine its approach to stakeholder engagement so that it supports agendas driven by others and leverages off their existing networks and strategies. In particular, this should focus on organisations that are seeking to work more collaboratively with the QMHC to achieve their organisational goals.
- Recalibrate its priorities placing a greater focus on systemic changes to support the needs of individuals with multiple challenges with a lessened focus on whole-of-government strategic planning.
- Place an increased focus on the following activities:
 - monitoring and implementing strategic and action plans
 - supporting stronger engagement at the local community level
 - the needs of Aboriginal and Torres Strait Islander communities and individuals with multiple challenges.
- Review the whole-of-government strategic plan and other strategies to leverage off the establishment of the Primary Health Networks and the introduction of the National Disability Insurance Scheme.
- Work with service providers and the Department of Health on strategies to build the capability of the workforce to treat individuals more holistically.
- Work more closely to foster partnerships with community organisations and government agencies to shape improved policy and practices for the broader community as well as those with particular vulnerabilities - with a particular focus on the culturally and linguistically diverse community; those in the criminal justice system; remote area communities; lesbian, gay, bisexual, transgender and intersex communities; those impacted by alcohol and other drug misuse; and suicide prevention advocates.

Chapter 5 – Customer focus

Legislative requirement

Under Section 11(2) of the Act, in exercising its functions, the QMHC must:

- engage and consult with:
 - people with mental health or substance misuse issues, and their families, carers and support persons; and
 - other members of the community to the extent the QMHC considers appropriate.
- take into account the particular views, needs and vulnerabilities of difference sections of the Queensland community, including:
 - Aboriginal and Torres Strait Islander communities
 - CALD communities
 - regional and remote communities, and
 - other groups at risk of marginalisation and discrimination.

QMHC agenda

The QMHC needs to be credible to make the greatest impact. A key component of this is to ensure those with lived experiences of mental health or substance misuse issues and their families, carers, inform its advice and support persons especially those that are more vulnerable. These views need to inform the QMHC's planning and decision-making.

Since its inception, the QMHC has focused on building relationships within and across the community to understand specific needs.

Key Paxton Partners survey item

The QMHC is utilising the views of people with lived experience, their families, carers and support people to inform planning and decision making (agree/disagree)

Achievements

There is strong evidence the QMHC has engaged and been inclusive with those with lived experience, in particular with NGOs and service providers. The Paxton Partners²³ 2016 data suggests a consistently positive response from stakeholders. Over the past three years, QMHC positive scores are quite stable at 58 per cent in 2014, 60 per cent in 2016, and 57 per cent in 2016 (Paxton: Figure 50). Respondents in board/executive and management roles (68 per cent) were much more positive about the QMHC efforts than those in administrative/frontline roles (42 and 39 per cent respectively) (Paxton: Figure 53).

²³ All Paxton Partners results are provided in Appendix 6.

This overall positive response was reflected in strong comments from stakeholders with the following two examples provided:

- The Townsville Suicide Prevention Network as an excellent example of how an agenda can be driven locally to bring a diverse group of stakeholders together, around a common cause with concrete actions. (Community managed organisation)
- QMHC prioritising support for children, families, and caregivers to promote good mental health and wellbeing, through the Start Well and Develop and Learn Well actions. (Government agency)

In terms of engagement with equity target groups, the QMHC has a strong positive response from the LGBTI community. Of the Paxton Partners respondents, the LGBTI group²⁴ had the highest agree response at 71 per cent (Paxton: Figure 61). QMHC has also been most successful in engaging with respondents in major cities. Paxton Partners respondents living in a major city (57 per cent) or inner regional Australia (41 per cent) were more positive than those in outer regional Australia (37 per cent). Respondent numbers for remote and very remote Australia were too low to draw conclusions and could demonstrate a lack of engagement with the QMHC (Paxton: Figure 62), which is consistent with previous Paxton Partners analysis.

Future directions

Stakeholders acknowledge it can be very challenging to consult more directly with members of the community with lived experience and frontline staff. There is an opportunity for the QMHC to have broader community engagement with a stronger place-based approach. Such an approach could support the QMHC to reach beyond its core customer base. Paxton Partners respondents from the CALD community were the least positive about the QMHC on this item with the lowest agree response at 48 per cent (Paxton: Figure 55).

A broad range of stakeholders (peak bodies, community managed organisations, unions, Paxton Partners respondents), suggested the following improvements:

- AOD needs to have as strong a voice as mental health
- QMHC need to involve a wider number of groups, not just a few, such as:
 - CALD communities
 - those that identify as LGBTI
 - Queenslanders living in remote and very remote areas, and
 - advocacy for consumers rights and the right for persons with a mental illness to participate in their care and treatment decisions.

These suggestions are reflected in stakeholder comments:

*The focus tends to be around mental health and not alcohol or other drugs.
(Peak body)*

QMHC needs to reach out beyond the mental health sector to the general population, for example the Cancer Council reaches out to the whole of

²⁴ Paxton Partners 2016 response rates for target groups are quite small.

community; it doesn't just focus on people with cancer. (Community managed organisation)

The QMHC engage and consult well, they focus on the consumers. QMHC could benefit from a place based approach, do they understand the specific needs at a local level for alcohol or other drugs, mental health or suicide? (Peak body)

Conclusion

The QMHC has been actively engaged in building mutually positive relationships with key stakeholders across the non-government sector, including peak bodies. In particular, there are strong relationships with those who represent vulnerable groups in society, such as the Aboriginal and Torres Strait Islander communities; children, families, caregivers of the mentally ill; and those active in suicide prevention.

However, the QMHC has the opportunity to improve the outcomes for key stakeholders group by:

- a stronger focus on working with community organisations and government agencies' leadership teams on approaches to engage frontline staff to better draw on the views of consumers, families and carers; to support the QMHC to better advocate for the rights of individuals to participate in their care and treatment decisions
- a greater focus on the perspectives and specific needs of other vulnerable groups, such as those in the criminal justice system, those impacted by AOD misuse, CALD communities, and Queenslanders living in remote and very remote areas.

Recommendations

- Work more closely to foster partnerships with community organisations and government agencies to shape improved policy and practices for the broader community as well as those with particular vulnerabilities - with a particular focus on the culturally and linguistically diverse community; those in the criminal justice system; remote area communities; lesbian, gay, bisexual, transgender and intersex communities; those impacted by alcohol and other drug misuse; and suicide prevention advocates.
- Work more closely with community organisations and government agencies' leadership teams to engage more directly with front line staff to better draw on the views of consumers, families and carers—to support a stronger place based approach and better advocate for the rights of individuals to participate in their care and treatment decisions.

Chapter 6 – Collaboration

Legislative requirement

The guiding principles in the Act includes the following:

An effective mental health and substance misuse system is the shared responsibility of the government and non-government sectors and requires a:

- coordinated and integrated approach, including across the areas of health, housing, employment, education, justice and policing; and
- commitment to communication and collaboration across public sector and publicly funded agencies, consumers and the community.

Section 11 of the Act requires the QMHC to engage and consult with Hospital and Health Boards, the government, non-government and private sectors.

Section 11(e) of the Act also provides that the QMHC's functions include 'to promote and facilitate the sharing of knowledge and ideas about mental health and substance misuse issues'.

Section 34 of the Act requires the QMHC and relevant agencies to work cooperatively in the exercise of their respective functions. Relevant agencies must also have regard to the whole-of-government strategic plan and consult with the QMHC on their activities, expenditure and initiatives as required under the whole-of-government strategic plan.

QMHC agenda

For the QMHC to realise its full potential it needs to effectively and consistently build collaboration to leverage off and inform the agendas of others. The QMHC is uniquely placed to work across and within the structures of the Queensland public sector to support the sector to work differently with each other to make a real difference to the QMHC agendas.

The progressive stages of maturity of collaboration are well defined in Table 2 (adapted from Himmelmann²⁵). These stages are part of the QMHC's evaluation framework.

²⁵ Himmelman, A., (2001). On coalitions and the transformation of power relations: collaborative betterment and collaborative empowerment. *American Journal of Community Psychology*, 29, 277–284.

Table 2: Stages and attributes of collaboration (adapted from Himmelman, 2006)

Stage	Definition	Attributes	Typical application
Networking	“exchanging information for mutual benefit”	Does not require much time or trust nor the sharing of turf	Networking is a very useful strategy for organisations that are in the initial stages of working relationships
Coordinating	“exchanging information for mutual benefit and altering activities for a common purpose”	Requires more time and trust but does not include the sharing of turf	Co-ordinating is often used to create more user-friendly access to programs, services, and systems
Cooperating	“exchanging information, altering activities, and sharing resources for mutual benefit and a common purpose”	Requires significant amounts of time, high levels of trust, and a significant sharing of turf	Co-operating may require complex organisational processes and agreements in order to achieve the expanded benefits of mutual action
Collaborating	“exchanging information, altering activities, sharing resources, and a willingness to enhance the capacity of another for mutual benefit and a common purpose”	Requires the highest levels of trust, considerable amounts of time, and an extensive sharing of turf	Collaboration also involves sharing risks, resources, and rewards and, when fully achieved, can produce the greatest benefits of mutual action

The 2016 Paxton Partners survey²⁶ was adapted with a series of new questions to gauge the effectiveness of the QMHC in forming effective partnerships.

Key Paxton Partners survey items

Please select the statement that best describes the level of collaboration between your organisation and the QMHC (no collaboration, networking, co-operating/co-ordinating, collaborating)

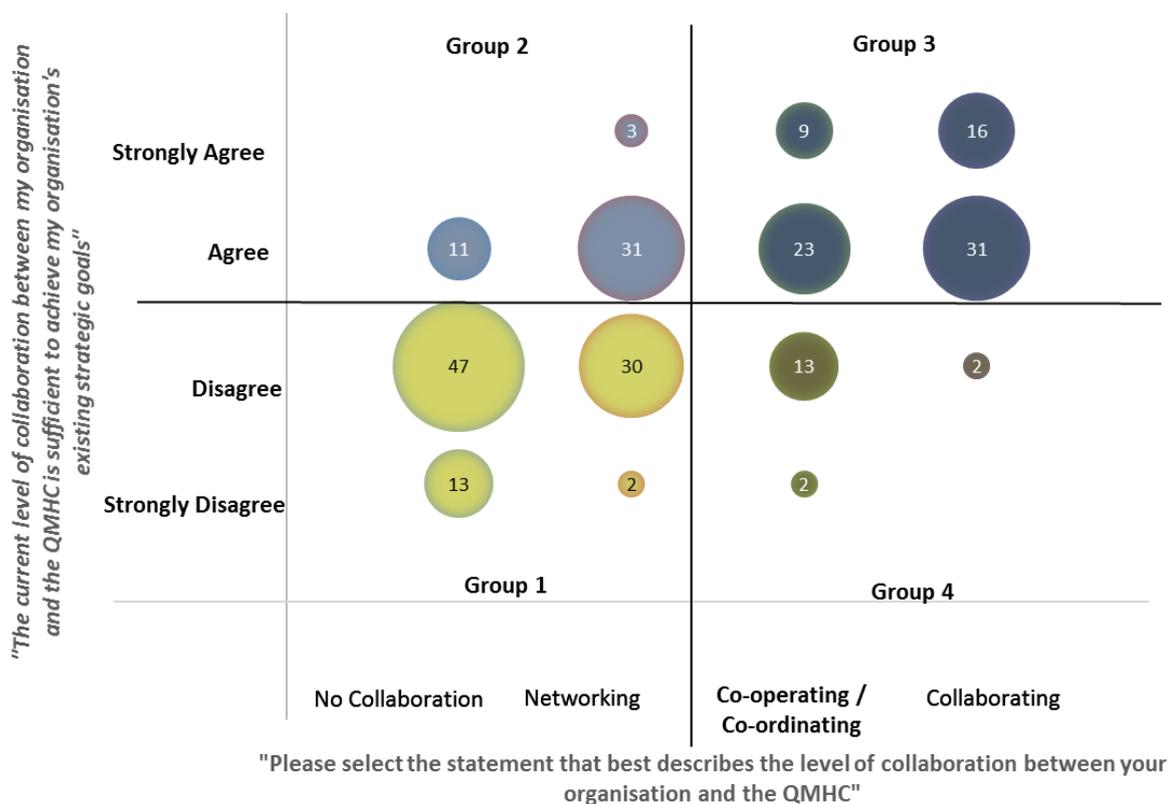
The current level of collaboration between my organisation and the QMHC is sufficient to achieve my organisation’s existing strategic goals (agree/disagree)

Collaboration with the QMHC will be essential to achieving my organisation’s future strategic goals (agree/disagree)

The Paxton Partners responses were plotted according to their perception of the level of current collaboration between their organisation and the QMHC, and the extent to which they agree that the current level of collaboration is sufficient to achieve their organisation’s strategic goals (Figure 4).

²⁶ All Paxton Partners survey results are provided in Appendix 6.

Figure 4: Current level of collaboration with QMHC vs agreement that current level of collaboration is sufficient (n=233)



In broad terms, respondents are aligned into four groups:

- Group 1: No/low level of collaboration and see this as insufficient
- Group 2: No/low level of collaboration and see this is sufficient
- Group 3: Mid-high level of collaboration and see this is sufficient
- Group 4: Mid-high level of collaboration and don't agree this is sufficient

Achievements

The QMHC has been actively involved in building collaboration across the health sector. Stakeholders appreciate the role and ability of QMHC as an independent entity, to bring together a broad range of stakeholders from multiple sectors. The investment by QMHC in collaborative efforts is reflected in its strong reputation and profile with stakeholders. Collaboration with the QMHC is viewed by 82 per cent of Paxton Partners respondents as key to achieving their future strategic goals, irrespective of the current level of collaboration (Paxton Report p. 48).

Key examples of collaboration suggested by stakeholders included:

- co-hosting open dialogues on reform agendas (AW&R group)
- policy dialogue (Government agency)
- connecting community groups to enable collaboration and support (Community managed organisation)
- bringing together key players (Peak body).

This value is reflected in stakeholder comments:

These (QMHC) introductions pave the way for strong relationships that would otherwise have taken a lot longer to foster, and opened doors that would have been difficult to have access to... (Community managed organisation)

It is clear that the QMHC recognises the value of effective engagement with stakeholders as crucial to achieving successful outcomes in areas that fall within the scope of its functions. (Unions)

We has established an excellent working relationship with the QMHC, which provides opportunities to align and collaborate in achieving improved outcomes for Aboriginal and Torres Strait Islander Queenslanders in a range of critical areas, such as over-representation of Aboriginal and Torres Strait Islander families and children in the child protection system; over-representation in the criminal justice system; domestic and family violence incidences; and broader socio-economic and health outcomes. (Government agency)

Results of the QMHC consultation have included community feedback that is broader than the QMHC's focus and has helped inform other areas of responsibility/interest within the broader Aboriginal and Torres Strait Islander remit (e.g. issues with the awareness and impact of the NDIS). This consultation process has involved engagement with community members and service providers and roundtables across the broad range of sector representatives. (Government agency)

Paxton Partners respondents identified a relatively even spread across the Himmelmann maturity continuum in their current collaboration with the QMHC. When you look at the 233 survey respondents assessment of the maturity of their organisation's level of collaboration with the QMHC (Paxton: Figure 63) you can see quite an even distribution:

- 30 per cent (n=71) identify as having no collaboration with the QMHC
- 28 per cent (n=66) identify as networking with the QMHC
- 20 per cent (n=47) identify as cooperating with the QMHC
- 22 per cent (n=49) identify as collaborating with the QMHC.

It is not surprising the current level of collaboration maturity is spread broadly among stakeholder groups. No doubt, this spread is a reflection of the evolving maturing of both the QMHC and stakeholder organisations, as their needs and expectations change over time. The QMHC's role brings strong potential for systemic change, but also has many challenges that will need to be addressed over time. As the QMHC evolves and matures, it will be important to have the right blend of capability to enable it to move from a strong policy focus to having a greater role in stakeholder engagement.

QMHC has been highly successful in building collaboration to meet the needs of the majority of its key stakeholders, especially those central to their agenda i.e. family members and caregivers of a person with lived experience. Fifty-three per cent of Paxton Partners respondents identified their current level of collaboration is sufficient to meet their organisational goals (Groups 2 and 3). This was true for family members (56 per cent), or caregivers of a person with lived experience (55 per cent) (Paxton: Figure 64).

Future directions

QMHC is encouraged to focus on those groups currently experiencing lower levels of collaboration and seeking greater collaboration (group 1). This includes HHS employees; advocacy/peak body employees; those working in frontline and management roles; and those in the drug and alcohol and justice sectors. Forty-seven per cent of Paxton Partners respondents identified their current level of collaboration is insufficient to meet their organisational goals (Groups 1 and 4). Notably, this was true for the following who were in Group 1: HHS employees (71 per cent); advocacy/peak body employees (63 per cent); and those working in the drug and alcohol (70 per cent) and justice (62 per cent) sectors (Paxton: Figures 64, 65, and 67). There was only one review submission received from a HHS, who have a key role to play in the QMHC agendas.

This shift in focus will require QMHC to enhance engagement with management and frontline employees who are far more likely than executive/board members to fall into Group 1. Paxton Partners respondents identifying as management (43 per cent) or frontline (59 per cent) were more likely to fall into Group 1, suggesting greater engagement with management and frontline remains an area for continued focus (Paxton: Figure 66).

In terms of the QMHC's agenda, the majority of Paxton Partners respondents working in the drug and alcohol (70 per cent) and justice sectors (62 per cent) also fell into Group 1, suggesting greater engagement with the AOD and justice sectors are also areas for continued focus (Paxton: Figure 67).

Of particular note is the relationship between QMHC and Department of Health. Clarity is required as to the role relationships and opportunities to leverage existing information and systems between QMHC and Department of Health. The challenges of contested territory is acknowledged by both QMHC and the Department of Health.

Stakeholder suggestions for improvement were:

- Increased focus on social determinants working with other agencies, rather than internal service delivery, such as assisted employment and accommodation and prevention; and drug supply and harm reduction. (Department of Health, peak body)
- Broadened and more effective planning and consultation with the following groups to ensure a more holistic approach to issues and recommendations (A&WR group, government agency, HHS, Department of Health, staff, unions):
 - existing networks led by others
 - frontline HHS employees
 - mental health clinicians
 - private sector
 - other government agencies
 - statutory bodies.

- Increased leverage off the QMHC's relationship with the Australian Institute for Suicide Research and Prevention to enhance service delivery. (Department of Health)
- More structured engagement and ongoing monitoring, and in many instances dedicated cultural change over time. (Staff)
- Auspicing and increased promotion of more regional forums of government, non-government and private sectors to drive integration. (HHS and peak body)

Conclusion

The QMHC has been successful in building broad collaboration across the health sector. However, to realise its full potential, greater collaboration is encouraged to actively contribute to the mutual benefit and common purpose of others.

QMHC is encouraged to focus on those groups currently experiencing lower levels of collaboration and seeking greater collaboration to achieve their organisational goals i.e. HHS employees; advocacy/peak body employees; those working in frontline and management roles; and those in the AOD and the justice sectors.

Of particular note is the relationship between QMHC and the Department of Health. Clarity is required as to the role relationships and opportunities to leverage off existing information and systems between QMHC and the Department of Health.

Recommendations

- Refine its approach to stakeholder engagement so that it supports agendas driven by others and leverages off their existing networks and strategies. In particular, this should focus on organisations that are seeking to work more collaboratively with the QMHC to achieve their organisational goals.
- Build stronger working relationships with the Department of Health and Hospital and Health Services to leverage off existing information and systems.

Chapter 7 – Out of scope observations

Stakeholders raised some issues that were outside the scope of the review of the QMHC. Although out of scope, the issues were seen as notable due to their potential impact on the effectiveness of the QMHC's operations (Table 3 and 4) or the impending review of the Act (Table 5).

The QMHC undertook a staff climate and wellness review in 2014-15²⁷, this work would likely be enhanced by regular monitoring of employee engagement and satisfaction. Understanding employee engagement is key to unlocking workforce potential. The annual whole-of-government *Working for Queensland* survey provides the opportunity for leaders to listen and respond to the views of their staff. In doing so, agencies are better placed to not only deal with the current challenges of the operating environment, but to thrive in them.

Participation in *Working for Queensland* from May 2017 would provide the QMHC with an ability to benchmark their employee engagement and satisfaction results against similar organisations across the Queensland public sector, such as Office of the Health Ombudsman, Queensland Family and Child Commission and the MHAODB in the Department of Health (Table 3).

There is an opportunity to improve clarity and understanding of the role relationships between QMHC and the Department of Health's MHAOD Branch in Clinical Excellence Division, Prevention Division and the Office of the Director-General. Issues identified included the responsibility for health prevention, sharing of information, access to health professionals, governance arrangements and reform agendas would benefit from greater clarity and support enhanced collaboration for heightened effectiveness (Table 4).

QMHC stakeholders made a number of suggestions as part of the review process for consideration as part of the review of the Act (Table 5).

²⁷ QMHC Annual Report 2014-15 p.49

Table 3: Internal workings of the QMHC

Celebrate

- Acknowledgment of achievements of Commissioner and the Executive Director (Staff)

Key areas to keep working on

- Increased transparency on decision-making priorities and strategic planning (Staff, Department of Health)
- Increased leverage off the QMHDAC—more promotion of the role of the QMHDAC, with an increased focus on frank and fearless advice to the QMHC (Staff)

Areas of concern

- Lack of resourcing (Commissioner, staff, peak bodies)
- Greater opportunity for staff to be trusted to consult and engage with stakeholders to increase staff engagement (Staff)
- Insufficient expertise in AOD within QMHC (QMHDAC and community managed organisation)

Table 4: Broader Department of Health issues

- Include QMHC support in the Charter letter to the Minister, and Director-General performance agreement.
- Assigning a lead role for the QMHC agenda to a Parliamentary Committee or Parliamentary Secretary.
- Formalise process whereby QMHC is routinely included in relevant Cabinet documents and Commonwealth and state matters.
- Increase the level of involvement of the QMHC in specific government processes, such as Cabinet submissions.
- Improved timeliness of governance arrangements i.e. appointment of QMHDAC (Commissioner, staff, QMHDAC).
- Review the role of MHAOD Branch in supporting QMHC accessing professional services within HHSs.

Table 5: Stakeholder's issues for consideration as part of the Legislative Review

- QMHC administer funding for programs and services in the mental health and alcohol and substance misuse sectors (the WA Mental Health Commission has this function).
- The QMHC structure could include Deputy Commissioners to assist the Commissioner, similar to the model in NSW.
- The title of the QMHDAC could include alcohol.
- The title of the QMHC could include reference to AOD misuse.
- The QMHC could oversee community visitors, a requirement under the *Mental Health Act 2016*, which is currently with the Department of Justice and Attorney-General [under the Guardianship and Administration Act (Queensland)].
- Suggested adoption of a provision in the *NZ Mental Health Commission Act 1998* (section 6) for the QMHC 'to act as an advocate for the interests of people with mental illness and their families' and 'to work independently'.
- The appointment of the Commissioner could be for a four or five-year term.
- Need a statement that provides greater clarity of the QMHC role.
- The QMHC could be provided with powers to hold health and non-health government departments accountable to the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–19* and action plans.
- The QMHC could become an independent entity and not be required to report to any Ministers.
- The Mental Health, Alcohol and Drug Services Plan being developed by the Department of Health excludes promotion, awareness and early intervention initiatives and that the Health Promotion Division of the Department of Health does not have provision in its budget for mental health.
- Need to distinguish the respective roles and responsibilities between the Queensland Health Promotion Commission and the QMHC with regard to prevention and early intervention services for people with chronic illness, including mental health and substance misuse issues.
- One submission from a union seeks the development of state wide policies or position statements on matters such as:
 - unaccompanied minors presenting for a mental health assessment
 - the admission of minors to adult wards
 - the adequacy of services to manage challenging behaviours
 - links between mental health and AODs misuse.

Recommendations

- Build stronger working relationships with the Department of Health and Hospital and Health Services to leverage off existing information and systems.
- Participate in the annual whole-of-government *Working for Queensland* survey.
- Department of Health consider the issues raised by stakeholders in the upcoming legislative review of the Act.

Appendix 1: Terms of Reference

Background

Section 55 of the *Queensland Mental Health Commission Act (2013)* (the Act) requires the Minister to arrange an independent review of the Mental Health Commission's (QMHC) performance of its functions within three years after the commencement of that section of the Act.

Objective

To confirm the QMHC is operating effectively in terms of its function, in the performance of its identified functions (as defined in S.11 of the Act); and to satisfy the legislative requirement for a review to take place, with recommendations to the Minister by 30 June 2016.

Review governance

The Public Service Commission (PSC) will auspice the independent review, with a project team led by Dr Leanne Gill, Executive Director Performance and Capability Development (SES 2H) and supported by Ms Juliet Dawson, Department of Health and Ms Andrea Hannah PSC.

The project team will report to a steering committee, chaired by Deputy Commissioner Peter McKay of the PSC.

The steering committee will include:

- Public Service Commission representative (chair)
- Department of the Premier and Cabinet
- Department of Health
- Department of Communities, Child Safety and Disability Services
- Department of Justice and Attorney-General
- Department of Housing and Public Works
- Queensland Police Service
- Department of Education and Training
- Queensland Council of Social Services

The steering committee will meet three times: at the commencement of the review; after the consultation and data collection phase is complete; and to consider the final draft report.

The costs associated with the project will be met by the Department of Health both in kind and funding of PSC resources.

Review approach

1. The independent nature of the review will enable a point in time assessment of performance/effectiveness of QMHC delivery on functions as defined under the QMHC Act, including a desktop comparison with the operation of similar commissions in other jurisdictions

2. The review will seek evidence on the extent the QMHC adds value to the people of Queensland by driving reform towards a more integrated, evidence-based, recovery oriented mental health and substance (consistent with the Object of the Act, Section 4); from which the review will provide a view of future priorities, based on its point in time assessment.
3. Given the role of the QHMC across government, the review will explore the extent the QMHC has been able to establish sustainable relationships and foster productive collaboration to facilitate the delivery of specific outcomes by relevant Departments/agencies.
4. The review will make a note of information outside the specific scope of the review that may be of assistance to the forthcoming review of legislation as defined under Section 56 of the Act; such as, expectations of stakeholders and the capability of the Commission to deliver its functions given its role as described under the Act.

Four underlying lines of enquiry

The functions under Section 11 of the Act can be grouped as follows:

- Why – Strategic Positioning – responding, Minister support, public sector performance, systemic focus
- What – Key Result Areas (Strategic Planning; Review Research and Report; Promotion and Awareness; Systemic Governance)
- How – Customer Focus – understand them, add value, evaluate impact
- How – Collaboration – integrated delivery, continuous improvement, satisfaction

Sources of information

- Desk top review – evidence on achievements, benchmarking with similar organisations in other jurisdictions
- Written submissions by invitation
- Structured interviews
- Focus Groups by invitation
- Paxton Partners' QMHC Evaluation Survey May 2016 (QMHC stakeholders)

Out of scope

- Legislative Review as outlined in Section 56 of the *QMHC Act 2013*
- QMHC resourcing, organisational governance and structure
- QMHC workforce processes and culture

Key stakeholders

- Dr Lesley van Schoubroeck Commissioner and executive QMHC
- Queensland Mental Health and Drug Advisory Council (QMHDAC)
- Professor Harvey Whiteford, immediate past Chairperson of QMHDAC
- Mark Henley, Director, Queensland Council of Social Services
- Mental Health Alcohol and Other Drugs Branch, Department of Health (Bill Kingswell, Sandra Eyre and Janet Martin)

- Rebecca MacBean, Queensland Network of Alcohol and other Drug Agencies
- Kris Trott, Chief Executive Officer, Queensland Alliance for Mental Health
- Noel Muller, President, Queensland Voice for Mental Health

Key stakeholder groups

- Queensland Primary Healthcare Networks
- State Government Hospital and Health Services
- State Government – Specialist Groups
- Peak bodies
- Consumer and carer representative organisations in mental health, drug abuse and suicide
- Key community managed organisations
- Key non-government alcohol and other drug organisations
- Queensland Mental Health Drug and Alcohol Advisory Council
- QMHC commissioner and staff
- Federal Government and NSW, WA and Vic Mental Health commissioners/equivalents
- Steering committee members and other government departments
- Public sector agencies with commitments in the QMHC action Plan
- Advocacy, workforce and research groups
- Select number of consumer representatives from Neighbourhood Centres
- Key Unions

Phases of the review process

Week 1: Initial scoping

(Resourcing requirements, planning, review TOR, identify all stakeholder groups, meet with key stakeholders, steering committee nominations by 29 April)

Week 2–3: Project Planning

(Desktop research, define stakeholder engagement and data capture methodologies, test approach with steering committee meeting)

Week 4–5: Stakeholder Engagement

(Conduct data capture i.e. survey, submissions by invitation, limited number of focus groups and interviews)

Week 6–7: Thematic Analysis

(Summarise key issues from engagement, test key themes with steering committee)

Week 8–9: Report Writing

(Consolidate findings and recommendations, submit draft report to steering committee for feedback and review)

Week 10: Communications

(Provide report to A/CCE to submit to the Minister for Health and Minister for Ambulance Services, supporting communication of outcomes to relevant stakeholders)

Appendix 2: Overview of the QMHC areas of focus (6 May 2016)

Initiative	Description	Progress to date	Next steps
KRA1: STRATEGIC PLANNING			
Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019			
Develop, monitor and report on the Strategic Plan implementation	<ul style="list-style-type: none"> The Queensland Mental Health Commission's role is to develop, and facilitate and report on the implementation of the Queensland Mental Health, Drug and Alcohol Strategic Plan. The Commission is also required to review the Strategic Plan within five years or earlier if directed by the Minister for Health. The whole-of-government strategic plan aims to improve mental health and wellbeing and includes six long-term outcomes: <ol style="list-style-type: none"> A population with good mental health and wellbeing Reduced stigma and discrimination Reduced avoidable harm People living with mental health difficulties or issues related to substance use have lives with purpose People living with mental illness and substance use disorders have better physical and oral health and live longer People living with mental illness and substance use disorders have positive experiences of their support, care and treatment. The Strategic Plan includes eight Shared Commitments to Action including developing indicators to measure progress towards improving mental health and wellbeing and achieving the six long-term outcomes (Shared Commitment to Action 8). 	<ul style="list-style-type: none"> The <i>Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019</i> was publicly released on 9 October 2014 by the previous Minister for Health, the Honourable Lawrence Springborg MP. The current Minister for Health and Minister for Ambulance Services, the Honourable Cameron Dick MP, has directed that implementation should continue but a review should be undertaken in 2016-17. The Strategic Plan <i>Annual Implementation Report 2014-15</i> outlining implementation of the eight Shared Commitments to Action was released in December 2015. The report includes actions by government and non-government organisations towards implementing the Strategic Plan's eight Shared Commitments to Action. The first <i>Performance Indicators Report</i> was released in December 2015 outlining indicators against the six long-term outcomes based on a set of principles. Gaps in data and indicators were also identified for future work. 	<ul style="list-style-type: none"> The Commission is planning to commence reviewing the Strategic Plan in early 2017 The next annual progress report, which will include implementation of associated action plans is due for public release in December 2016. The second Performance Indicators Report is also expected to be released in December 2016 with updated data and some gaps in data being filled. The Queensland Mental Health and Drug Advisory Council must be consulted in the review of the Strategic Plan as required by the Queensland Mental Health Commission Act 2013 (the Act).

Preventing and reducing the adverse impact of alcohol and other drugs on Queenslanders			
Developing and supporting the implementation of the <i>Queensland Alcohol and other Drugs Action Plan 2015-17</i>	<ul style="list-style-type: none"> The Strategic Plan committed to identifying and implementing actions to prevent and reduce the adverse impact of alcohol and other drugs on the health and wellbeing of Queenslanders (Shared Commitment to Action 3). 	<ul style="list-style-type: none"> The <i>Queensland Alcohol and Other Drugs Action Plan 2015-17</i> was by the Minister for Health and Minister for Ambulance Services, the Honourable Cameron Dick MP on 7 December 2015. The Action Plan aims to prevent and reduce the adverse impact of alcohol and other drugs on the health and wellbeing of Queenslanders. It includes 54 actions to be undertaken by 13 agencies under three priority areas aligned with the <i>National Drug Strategy 2010-2015</i>: Demand reduction to prevent the uptake and delay the onset of drug use and reduce the use of drugs; The Commission has established the Queensland Alcohol and Other Drugs Reference Group to oversee the implementation of the Action Plan and identify emerging issues and good practice. The members of the Reference Group include non-government organisations, government organisations and a representative from Queensland's Primary Health Networks. 	<ul style="list-style-type: none"> Implementation of actions is being monitored by the Commission and will be reported in Strategic Plan's next <i>Annual Implementation Report</i> due in December 2016. The Action Plan will be reviewed after 12 months.
	<ul style="list-style-type: none"> The Commission will commence research into identifying effective ways of reducing stigma and discrimination which has a negative impact on mental health and wellbeing of people living with problematic alcohol and other drug use. 	<ul style="list-style-type: none"> The project will identify areas of focus to address stigma and discrimination. The Commission will be seeking tenders to undertake the research. The research will include at least 20 case studies documenting the lived experience of people living with problematic alcohol and other drug use. 	<ul style="list-style-type: none"> The research is expected to be completed in early 2017.
Improving the mental health and wellbeing of people living in rural and remote Queensland			
A whole-of-government Rural and Remote Action Plan 2016-18.	<ul style="list-style-type: none"> The action plan will aim to improve the mental health and wellbeing of people living in rural and remote Queensland. This will satisfy one of the commitments made in the Strategic Plan (Shared Commitment to Action 3). 	<ul style="list-style-type: none"> The discussion paper <i>Towards a Queensland Rural and Remote Mental Health and Wellbeing Action Plan</i> released on 22 March 2016 is open for public consultation until Friday 29 April 2016. 	<ul style="list-style-type: none"> The public release of the Action Plan is expected for mid-2016.

	<ul style="list-style-type: none"> It will build on existing Action Plans which focus on promotion, prevention and early intervention, suicide prevention and reducing and preventing the adverse impact of alcohol and other drugs. 		
Consumer experiences of telehealth/telepsychiatry	<ul style="list-style-type: none"> Use of telehealth and telepsychiatry is one of the highest in the country. It is an important way consumers, who live in rural and remote Queensland, are able to access treatment and care. The Commission engaged Enlightened Consultants to interview consumers, their supporters and clinicians about their experiences of telepsychiatry and how the user experience might be enhanced in the future. 	<ul style="list-style-type: none"> Enlightened Consultants has provided the Commission with their final report based on in depth interviews with 21 regular users of telepsychiatry. Four main themes emerged: <ul style="list-style-type: none"> telepsychiatry is a valued part of mental health care for people living in rural areas the ability to form a meaningful and positive relationship with the treating team is central to a positive experience of telepsychiatry having the same treating team over time can also increase satisfaction with telepsychiatry some consumers would like to involve a wider range of support persons in their telepsychiatry consultations and have access to telepsychiatry from home. 	<ul style="list-style-type: none"> The report <i>Informing the future of Queensland's Telepsychiatry Services</i> has been publicly released and the Commission has provided a copy of the report to the Executive Director of Mental Health Alcohol and Other Drugs Branch, the Chief Psychiatrist, Hospital and Health Services and the Royal Australian and New Zealand College of Psychiatry to support improved use of telepsychiatry.
Social outcomes through procurement			
Increasing employment and training opportunities through social enterprise and social procurement.	<ul style="list-style-type: none"> The focus of this work is to increase employment and training opportunities for people living with mental illness. This work supports the Strategic Plan outcomes including that people living with mental health difficulties or issues related to substance use have lives with purpose. Action 77 of the <i>Early Action: Promotion, Prevention and Early Intervention Action Plan 2015-17</i> commits the Commission to increase opportunities for people living with mental illness to gain employment through social enterprises. 	<ul style="list-style-type: none"> The Commission engaged Social Outcomes to investigate and prepare the <i>Social Enterprises for Employment Outcomes paper</i> on employment outcomes for people with mental health difficulties or issues related to substance use, which was released in August 2015. The aim of the paper was to stimulate discussion and increase understanding about the potential for social enterprises to increase the employment opportunities for people with mental illness and substance use issues. The Commission has to date provided \$50,000 non-recurrent funding to the Toowoomba Clubhouse and the Darling Downs and West Moreton Primary Health Network for a joint initiative to build the 	<ul style="list-style-type: none"> The Social Enterprises for Employment Outcomes paper is available on the Commission's website The Toowoomba Social Procurement Project is a six month project that commenced in March 2016. A report will be provided to the Commission at the end of the project. The outcomes of the discussion with the Department of Housing and Public Works are ongoing and not yet been finalised.

		<p>capacity of the social enterprise community in Toowoomba to capitalise on current social procurement opportunities in the region.</p> <ul style="list-style-type: none"> The Commission is currently in discussion with the Department of Housing and Public Works about ways to build the capacity of Queensland Government and social enterprise organisations to enter into social procurement arrangements. 	
Willing to Work Inquiry	<ul style="list-style-type: none"> The Australian Human Rights Commission has undertaken a national inquiry into employment discrimination against older Australians and Australians with a disability. 	<ul style="list-style-type: none"> The Commission made a joint submission in December 2015 with the Anti-Discrimination Commission Queensland (ADCQ) to the Australian Human Rights Commission's <i>Willing to Work: Inquiry into employment discrimination against older Australians and Australians with a disability</i>. The submission identified the barriers people with a disability or mental illness experience in obtaining and keeping a job and proposes a number of solutions to these barriers. The submission included case studies of how these barriers impact and provides some examples of good practice occurring here in Queensland and overseas. 	<ul style="list-style-type: none"> The Australian Human Rights Commission released its Willing to Work Inquiry Report in May 2016. The next step is for the Australian Government to respond to the report and outline whether and how it will implement the Inquiry's recommendations.
Improving the mental health and wellbeing of Aboriginal and Torres Strait Islander peoples			
Developing a whole-of-government Queensland Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Action Plan.	<ul style="list-style-type: none"> The Action Plan will aim to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander Queenslanders. It will focus beyond health services and will build on existing Action Plans which focus on promotion, prevention and early intervention, suicide prevention and reducing and preventing the adverse impact of alcohol and other drugs. 	<ul style="list-style-type: none"> The Discussion Paper <i>Improving Aboriginal and Torres Strait Islander Social and Emotional Wellbeing in Queensland</i> was released on 31 March 2016 for consultation to 30 June 2016. It is envisaged that the Action Plan will focus on factors which will contribute to improved social and emotional wellbeing of Aboriginal and Torres Strait Islander Queenslanders by supporting: <ol style="list-style-type: none"> Community participation Community and family resilience Individual social and emotional wellbeing Community consultations are being held in Ipswich, Townsville, Logan, Toowoomba, 	<ul style="list-style-type: none"> The Action Plan is planned for public release by the Commission in September 2016.

		Thursday Island, Mount Isa, Brisbane, Rockhampton and Cairns.	
	<ul style="list-style-type: none"> The Commission is developing KPIs across the continuum of care for Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, alcohol and drugs. 	<ul style="list-style-type: none"> The Commission engaged Edward Tilton Consulting Health and Social Policy Services to conduct research and consult with leaders in the health sector and two communities to identify a potential framework to measure the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. The Key performance indicators for Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and substance misuse in Queensland released on 31 March 2016 identified 17 indicators in three domains: Health and wellbeing status/outcomes; Health system performance and social and cultural determinants. 	<ul style="list-style-type: none"> The report recommendations will be considered during the consultations to develop the Action Plan.
The <i>National Empowerment Project</i> Pilot in Kuranda and Cherbourg	<ul style="list-style-type: none"> The National Empowerment Project (NEP) is an innovative Aboriginal and Torres Strait Islander led project that works directly with communities to address their cultural, social and emotional wellbeing. The program aims to strengthen cultural, social and emotional wellbeing. It also aims to increase resilience, and reduce psychological and community distress and high rates of suicide in Aboriginal and Torres Strait Islander communities 	<ul style="list-style-type: none"> The Aboriginal and Torres Strait Islander Community Consultants in Cherbourg and Kuranda deliver NEP in their communities. They have completed a Certificate IV Mental Health (non-clinical) course and the Australian Indigenous Leadership Centre Leadership Training. NEP supports the wider community through Mental Health First Aid and the Cultural Social and Emotional Wellbeing programs to empower members of the community with the knowledge and tools to assess, prevent and respond to mental health issues and be able refer when necessary. 	<ul style="list-style-type: none"> In 2015 the Commission committed to a five year strategy to continue the NEP Pilot. The pilot may also extend to other communities
Supporting people with mental health in the criminal justice system			
Facilitate and support actions to improve the wellbeing of people in the criminal justice system	<ul style="list-style-type: none"> Improving the interaction between the mental health and the criminal justice systems is a priority action area under the <i>Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019</i>. 	<ul style="list-style-type: none"> The Commission is facilitating a Strategic Conversation process to identify ways to improve responses to people living with mental illness or experiencing a mental health crisis when they interact with police. They will explore: <ul style="list-style-type: none"> The interaction between police and people with a mental illness, or people who may 	<ul style="list-style-type: none"> Three Strategic Conversations have been held as at 6 May 2016. The next Strategic Conversation will hear from those with a lived experience. We anticipate holding Strategic Conversations that will also hear from police and others.

		<p>be experiencing a mental health related crisis</p> <ul style="list-style-type: none"> - The intersection between police and mental health systems and services in the response to, and management of, people with a mental illness or people who may be experiencing a mental health related crisis - Opportunities to improve outcomes for people with a mental illness, or people who may be experiencing a mental health related crisis that come into contact with police. • The Strategic Conversations use a transformational leadership approach, which has been shown to encourage innovation and lead to better organisational outcomes. Transformational leadership is a process which leads to positive change by developing a clear vision and inspiring others to change expectations, perceptions and motivations to work collaboratively towards achieving common goals. 	
Advocacy and rights protection within the mental health, drug and alcohol service systems			
Research into improving outcomes at the interface.	<ul style="list-style-type: none"> • The research will examine the use of mental health clinicians in police communications; mental health services support of siege negotiators; and police interviews with people living with mental illness. 	<ul style="list-style-type: none"> • Being undertaken by the Queensland Forensic Mental Health Service and funded by the Commission. 	<ul style="list-style-type: none"> • A final report is due in September 2016.
<i>Human Rights Act</i> Inquiry	<ul style="list-style-type: none"> • Providing a submission to the Queensland Parliament's Inquiry into whether Queensland should have a <i>Human Rights Act</i>. 	<ul style="list-style-type: none"> • The Commission provided a submission to the Inquiry on 18 April which supported Queensland having a <i>Human Rights Act</i> which protected the rights of those living with mental illness and alcohol and other drug problems. It also noted that protecting the human rights of all Queenslanders is fundamental to good mental health and wellbeing. 	<ul style="list-style-type: none"> • The Parliamentary Committee is due to make recommendations later in 2016.

Supporting stronger community mental health and wellbeing			
Support participation and knowledge sharing	<ul style="list-style-type: none"> The <i>Stronger Community Mental Health and Wellbeing Grants Program</i> has been established to support innovation and build the evidence base about locally-led solutions to address factors that influence good mental health and wellbeing. The program has funded a range of projects that are aimed to: <ul style="list-style-type: none"> increase community and individual connectedness raise community awareness of mental illness and substance use disorders build community capacity for improving mental health and wellbeing support social inclusion and community participation for those experiencing mental health problems and problems related to alcohol and other drug use Community, local government and non-government organisations are able to apply for grants of up to \$50,000 through this program. 	<ul style="list-style-type: none"> Since 2014-2015, the Commission has awarded 51 grants to the value of \$1.48 million through the <i>Stronger Community Mental Health and Wellbeing Grants Program</i>. The program has funded activities that promote good mental health and wellbeing in over 50 locations across Queensland between Cape York through to the Gold Coast and extended as far west as Mount Isa. To date, with the support of the grants program: <ul style="list-style-type: none"> 821 people have received training; examples of training include mental health first aid and ASIST training 13 people have become accredited instructors or facilitators 1,648 people have attended workshops on mental health and wellbeing 47 people have been trained as speakers or mentors. - 	<ul style="list-style-type: none"> The Commission is preparing a summary report on the grants program for the 2014-15 period highlighting key achievements under the program. Progress with grants issued in the 2015-2016 rounds continues to be monitored, while planning for the 2016-17 grants round is soon to commence.
KRA 2: REVIEW, RESEARCH AND REPORTING			
Support the Department of Housing and Public Works to implement strategies to improve the sustainability of social housing tenancies			
Publish the Ordinary Report on Social Housing systemic issues and support implementation of its recommendations	<ul style="list-style-type: none"> The Commission examined the impact of the implementation of Queensland's anti-social behaviour management policy on social housing tenants who are experiencing mental illness, mental health difficulties and substance use problems. 	<ul style="list-style-type: none"> In June 2015, the Minister for Health and Minister for Ambulance Services tabled the Commission's Social Housing: Systemic issues for tenants with complex needs in the Queensland Parliament. The report outlined 12 recommendations to address systemic issues and improve the sustainability of social housing tenancies for people with complex needs. The report's recommendations were all accepted or supported by the Department of Housing and Public Works, Queensland Health and the Department of Communities, Child Safety and Disability Services. 	<ul style="list-style-type: none"> The Commission continues to support agencies to implement the recommendations. The Commission is currently involved in a number of governance committees that support the implementation of the Department of Housing and Public Works <i>Mental Health Demonstration Pilot Project</i>.

New mental health legislation in Queensland			
Influence the review of the <i>Mental Health Act 2000</i> and the development of new mental health legislation in Queensland.	<ul style="list-style-type: none"> • Queensland Health commenced a review of the <i>Mental Health Act 2000</i> in 2014. The Commission undertook consultations with consumer, families and carers and service providers to develop submissions and to support these groups to make their own submissions. • The Commission's submissions focused on ensuring Queensland had contemporary mental health legislation which adopted a recovery-oriented and least restrictive approach to involuntary treatment which protects and respects human rights. 	<ul style="list-style-type: none"> • The Commission's submissions have informed the new <i>Mental Health Act 2016</i> which was passed by the Parliament in 2016 including: <ul style="list-style-type: none"> - The introduction of a support person nominated by the consumer to help them express their wishes - Increased rights protection for consumers, families and carers. 	<ul style="list-style-type: none"> • The new Act is expected to commence operation in November 2016. • The Commission is participating in a wide range of working groups to inform its implementation including those focused on the new Independent Patient Rights Advisors, the use of Advance Health Directives and new Examination Authorities.
Support Least restrictive practices in mental health wards			
Conduct a review into least restrictive practices in mental health wards	<ul style="list-style-type: none"> • The Commission prepared a report that outlines options for reform towards a more recovery-orientated and least restrictive approach to mental health services being delivered in acute mental health wards. • 	<ul style="list-style-type: none"> • In December 2014, the Commission published the <i>Options for Reform: Moving towards a recovery-orientated, least restrictive approach report</i>, which was prepared by the University of Melbourne. • The report was based on a literature review and facilitated forums undertaken by the University of Melbourne and in consultation with members of the Queensland Mental Health and Drug Advisory Council, consumers, families, carers and senior clinicians. 	<ul style="list-style-type: none"> • The Commission is planning to publish a progress update on the Hospital and Health Services implementation of the options for reform in May 2016.
KRA 3: AWARENESS AND PROMOTION			
Improve the mental health and wellbeing of all Queenslanders and reducing the incidence, severity and duration of mental illness			
Monitor and support the implementation of the <i>Early Action: Promotion, Prevention and Early Intervention Action Plan 2015-17</i>	<ul style="list-style-type: none"> • The Strategic Plan includes a commitment to improve mental health and wellbeing, reduce the incidence, severity and duration of mental illness and mental health problems (Shared Commitment to Action 2). • This requires whole-of-government and whole-of-community action. 	<ul style="list-style-type: none"> • The <i>Early Action: Queensland Mental Health Promotion, Prevention and Early Intervention Action Plan 2015-17</i> was released in October 2015. • It aims to improve the mental health and wellbeing of Queenslanders and to reduce the incidence, severity and duration of mental illness and mental health problems. 	<ul style="list-style-type: none"> • Implementation of actions is being monitored by the Commission and will be reported in Strategic Plan's next Annual Implementation Report due in December 2016. • The Action Plan will be reviewed after 12 months.

		<ul style="list-style-type: none"> • The action plan has a focus on life stages and transitions that require specific conditions and opportunities to ensure best outcomes for individuals and communities. It contains a total of 99 new and continuing actions by 16 Queensland Government agencies. • The QMHC has established working groups to oversee the implementation of the action plan and identify emerging issues and good practice. The following working groups have been established: <ul style="list-style-type: none"> - Start, Develop and Learn Well - Work Well - Live Well - Age Well 	
A renewed approach to suicide prevention			
<p>Monitor and support the implementation of the <i>Queensland Suicide Prevention Action Plan 2015-17</i></p>	<ul style="list-style-type: none"> • The Strategic Plan includes a commitment to renew Queensland's approach to suicide prevention (Shared Commitment to Action 3). • This requires whole-of-government and whole-of-community action. 	<ul style="list-style-type: none"> • The <i>Queensland Suicide Prevention Action Plan 2015-17</i> was released by the in September 2015. It aims to reduce the impact of suicide on Queenslanders. • Action Plan outlines 42 actions by 12 government agencies across four related priority areas: <ol style="list-style-type: none"> 1. Stronger community awareness and capacity 2. Improved service system responses and capacity 3. Focused support for vulnerable groups 4. A stronger, more accessible evidence base • The implementation of the Action Plan in being overseen by a newly established Queensland Suicide Prevention Reference Group convened by the Commission. Members of the Reference Group consist of government and non-government organisations including those supporting people affected by suicide. 	<ul style="list-style-type: none"> • Implementation of actions is being monitored by the Commission and will be reported in Strategic Plan's next Annual Implementation Report due in December 2016. • The Action Plan will be reviewed after 12 months.

	<ul style="list-style-type: none"> Locally led pilot of an Aboriginal and Torres Strait Islander place-based approach (suicide prevention) 	<ul style="list-style-type: none"> The Commission engaged consultant Barbara Schmidt and Associates to conduct a review in August 2015 in response to raised concerns regarding the out of services to prevent youth suicide in Townsville. Consultation meetings were held with the Townsville Aboriginal and Torres Strait Islander Service and the North Queensland Primary Health Network, the Townsville Hospital and Health Service. Consultations shared information, discussed experiences in engagement, services and data. 	<ul style="list-style-type: none"> Work has commenced to develop a local suicide action plan which will be led by a local consortium consisting of the Primary Health Network and other local stakeholders. The Commission continues to maintain involvement by participating at the committee meetings.
Monitor and support the implementation of the <i>Queensland Suicide Prevention Action Plan 2015-17</i>	<ul style="list-style-type: none"> Develop and implement data and information sharing framework to support suicide prevention. The framework is due for completion by late April 2016. The commitment to develop and implement the framework arose from feedback provided by stakeholders during consultations to develop the Action Plan. Stakeholders identified the need to improve access to research about what works to prevent and respond to suicide. Additionally, a lack of local level data was identified as a barrier to determine if suicide programs and initiatives worked to reduce the risk of suicide. 	<ul style="list-style-type: none"> The Data and Information Sharing framework project extends beyond collecting and providing suicide data to include improved dissemination of evidence about what works to reduce suicide and manage suicide risk. The Queensland Advisory Group on Suicide Information and Data (QAGSID formerly the Queensland Advisory Group on Suicide) has recently provided on a draft discussion paper which is currently informing development of the final paper. The framework includes the following elements: <ul style="list-style-type: none"> Enhancing current data collection by identifying ways to fill gaps, for example LGBTI and ethnicity Consolidating current data and information collections Implementing a mechanism for sharing data and information to inform cross sectoral coordination and response processes in a more timely way Implementing and supporting a mechanism to customise data and information to inform local action. 	<ul style="list-style-type: none"> The final draft protocol guidelines are due to be provided to the Commission by mid-April 2016 for consideration before distribution. Feedback from QAGSID has been collated and is informing development of a final draft paper which will be circulated to QAGSID and other key stakeholders for comments before the Data and Information Sharing framework is delivered. There are many complexities and it is expected that it will take time to finalise.
	<ul style="list-style-type: none"> Develop tailored suicide prevention training and materials to support culturally and linguistically diverse communities to recognise and support a 	<ul style="list-style-type: none"> <i>Queensland Suicide Prevention Acton Plan 2015-17</i> Action 33 (Priority Area 3). 	

	<p>person who is at risk of suicide by end of August 2016.</p>	<ul style="list-style-type: none"> • Despite people from culturally and linguistically diverse backgrounds experiencing higher levels of socially and economically determined risk factors for poor mental health and wellbeing and mental illness, they continue to be under-represented in service access and utilisation figures. • If culturally appropriate support is considered mainstream and not accessible, or information is not available in a person's community language, it is potentially a key issue for a person at risk not contacting a suicide prevention services when they need help. Additionally there are different cultural understandings surrounding suicide, with a strong stigma associated with suicide for a number of culturally and linguistically diverse communities. • As a result, people may not seek support if they are at risk of suicide or self-harm and if they do, their cultural background may lead them to describe the problem in ways that are unfamiliar to service providers, or not disclose their experiences, which can cause misunderstanding. 	
	<ul style="list-style-type: none"> • Review the accessibility of resources to assist and support people bereaved by suicide. • The report with findings is expected to be finalised by mid-year 2016. 	<ul style="list-style-type: none"> • <i>Queensland Suicide Prevention Acton Plan 2015-17</i> Action 4 (Priority Area 1). • Although many organisations provide support to people bereaved by suicide, including through telephone support lines and on-line resources, during consultations for development of the Action Plan, people with a lived experience identified that there are extensive resources and information available but people do not know how to access it, or whether or not the information is based on evidence, constitutes best-practice or is relevant and appropriate to different population groups. • This project is about providing better ways to reach those who are affected and minimise the 	<ul style="list-style-type: none"> • Orygen, the National Centre of Excellence in Youth Mental Health was recommended as the successful organisation to deliver the project which is due to commence in late April and conclude in late July 2016. • Orygen will work in partnership on the project with researchers from the University of Queensland, University of New South Wales and Suicide Prevention Australia.

		post traumatic effects to suicide bereaved individuals and groups. Improved access to support and resources is also important in reducing the risk of secondary suicides by those who may have increased vulnerability due to loss or exposure, and for those who have previously attempted suicide.	
Facilitate and promote whole-of-government actions to improve mental health awareness, prevention and early intervention			
Facilitate and promote whole-of-government actions to improve mental health awareness, prevention and early intervention	<ul style="list-style-type: none"> Support a pilot for peer support in perinatal and infant mental health. Support funding is being provided by the Statewide Maternity and Neonatal Clinical Network. 	<ul style="list-style-type: none"> Two contracts have been signed with the Women's Health Queensland Wide and Children's Health Queensland (Queensland Centre for Perinatal and Infant Mental Health). The pilot is expected to be finalised by December 2016. 	<ul style="list-style-type: none"> Work has commenced and is being overseen by the established Project Steering and Working groups.
	<ul style="list-style-type: none"> Support measures to improve mental health early intervention in schools (Ed-LinQ Renewal Project) that involves: <ul style="list-style-type: none"> undertaking a plan to renew the Queensland Ed-LinQ initiative model including considering the necessary expansion into rural and remote HHSs funding the delivery of joint professional development to education, mental health and community service providers across the state (including rural and remote Hospital and Health Services that don't have an Ed-LinQ program) 	<ul style="list-style-type: none"> The funding agreement has been secured with the Children's Health Queensland HHS Child and Youth Mental Health Service to renew the Queensland Ed-LinQ initiative model with a report due in September 2016. 	
	<ul style="list-style-type: none"> Develop and support a coordinated approach to mental health awareness training by: <ul style="list-style-type: none"> undertaking an independent audit of mental health programs across Queensland proposing a model for improved coordination and support of mental health awareness training across Queensland. 	<ul style="list-style-type: none"> A funding agreement with Open Minds has been established to undertake an audit of mental health awareness programs across Queensland and report on the availability, delivery and reach. 	<ul style="list-style-type: none"> It is anticipated that once the audit and report have been accepted that Open Minds will then develop a proposal outlining the recommended model by end of June 2017.
	<ul style="list-style-type: none"> Develop and support a localised wellbeing hub in three local government areas to trial and review the establishment of a regional hub 	<ul style="list-style-type: none"> Three contracts have been awarded to three separate organisations. 	<ul style="list-style-type: none"> Each Hub will provide a regional mental health and wellbeing plan by April 2016.

	<p>model that will improve community mental health and wellbeing.</p>	<ul style="list-style-type: none"> The proposed regional mental health and wellbeing model will be developed and submitted to the Commission by end of July 2016; a final report on progress and proposed directions for 2017 is expected to be provided to the Commission by December 2016. 	
	<ul style="list-style-type: none"> Develop and support a coordinated approach to stigma reduction through consumer contact by undertaking research with regard to stigma experienced by people with lived experience that are seeking and obtaining work. 	<ul style="list-style-type: none"> The Commission is in the process of offering a contract to an external organisation to undertake the research. 	<ul style="list-style-type: none"> A final report is expected by September 2016.
KRA 4— SYSTEMIC GOVERNANCE			
Improving lived experience engagement and leadership			
Support and facilitate consumer, family and carer engagement and leadership	<ul style="list-style-type: none"> A key element of the Strategic Plan is to promote engagement and leadership of individuals, families and carers across all levels of the mental health, alcohol and other drugs systems. The Commission has been undertaking a state-wide survey of public, private and NGO mental health and alcohol and drug services to determine how services across the state are current engaging individuals, families and carers. The survey will assist the Commission to identify current strengths and gaps in engagement and set a baseline against which changes in engagement can be measured over time. 	<ul style="list-style-type: none"> The Commission has been working with Urbis Consultants to develop and implement the survey. Consultations were completed with government and non-government organisations in late 2015 to develop the survey tool. An invitation to participate in the survey was issued on 8 February 2016 to public, private and non-government organisations delivering mental health, alcohol and other drugs services in Queensland. The survey closed on 21 March 2016. 	<ul style="list-style-type: none"> Urbis are analysing the survey results with a final report to be provided to the Commission mid- May 2016. The report will outline the survey findings including an analysis of differences between the public and non-government sectors and between the mental health and the alcohol and other drugs sectors. This information will be shared with participating services and will be publicly released.
	<ul style="list-style-type: none"> There are numerous local, state and national of frameworks outlining how services might engage with individuals, families and carers as part of their service improvement activities. These frameworks articulate a wide array of underlying principals and strategies. The Commission is reviewing these frameworks and consulting with key stakeholders to develop 	<ul style="list-style-type: none"> The Commission is working with a consortium, led by Queensland Alliance for Mental Health working in partnership with Queensland Network of Alcohol and other Drug Agencies and Enlightened Consultants to deliver this project. The consortium has completed a review of existing frameworks and literature to identify 	<ul style="list-style-type: none"> There are numerous local, state and national of frameworks outlining how services might engage with individuals, families and carers as part of their service improvement activities. These frameworks articulate a wide array of underlying principals and strategies. The Commission is reviewing these frameworks and consulting with key stakeholders to develop a

	<p>a contemporary set of best practice principles that can be used to promote an effective and consistent approach to engagement across the mental health and alcohol and other drugs sectors.</p>	<p>existing best practice concepts and principles in both the mental health and alcohol and other drugs sectors.</p> <ul style="list-style-type: none"> • A series of online and face-to-face think tanks have also been completed to identify any novel principles not articulated in previous frameworks and literature that may inform the project. 	<p>contemporary set of best practice principles that can be used to promote an effective and consistent approach to engagement across the mental health and alcohol and other drugs sectors.</p>
<p>Engage leading consumers, family or carer representatives to participate in and lead significant projects</p>	<ul style="list-style-type: none"> • The perception that people with a lived experience don't have a valuable contribution to make is known to be a major barrier to their active involvement in the design and delivery of mental health, alcohol and other drug services. • The Commission is planning a forum for mid-2016 to identify opportunities to promote the contribution made by those with a lived experience to the mental health system. • The forum will bring together thought leaders and decision makers to identify options for promoting lived experience, set priorities and explore opportunities for collective action. • While acknowledging that lived experience comes in many forms, this forum will focus specifically on promoting the contribution that can be made by those with a history of mental illness and recovery. 	<ul style="list-style-type: none"> • The Commission's lived experience consultant Dr Louise Byrne is working with Commission staff to design the mid-year forum, and prepare a discussion paper to support the forum. • The Commission is considering options for how to approach the contribution of lived experience in the alcohol and other drug sector. 	<ul style="list-style-type: none"> • The forum has been tentatively scheduled for early July. • Work has commenced to scope the purpose and design of the forum and finalise a discussion paper.

Appendix 3: Stakeholders identified and engagement strategies

Stakeholders identified and engagement strategies				
		Key stakeholder individuals/organisations	Invited to provide a submission	Invited to scheduled structured interview
Queensland Mental Health Commission				
Commissioner/Executive	1.1	Lesley van Schoubroeck Carmel Ybarlucea Michael Corne	1	1
Staff	1.2	Bec Tan Annette Mullen Deborah Pratt Josephine Peat Kate Southwell Mandy Beaumont Marianne Zangari Nicole Hunter Nusch Herman Russell Evans Simone Caynes	13	13
QMHDAC	1.3	Jan Kealton Kingsely Bedwell Mitchell Giles Ettienne Roux Harvey Whiteford (past president) – scoping interview only		4
Department of Health, peak bodies, other government agencies				
Department of Health	2.1	<ul style="list-style-type: none"> Mental Health Alcohol and Other Drugs Branch (Department of Health) Preventative Health Branch Aboriginal and Torres Strait Islander Health Branch 	3	
Peak bodies	2.2	<ul style="list-style-type: none"> Queensland Council of Social Services (QCOSS) Queensland Alliance for Mental Health Queensland Network of Alcohol and Other Drug Agencies (QNADA) Queensland Aboriginal and Torres Strait Islander Health Council Queensland Indigenous Substance Misuse Council Private Hospitals Association 	6	QCOSS

Government agencies and QMHC action plan agencies	2.3	<ul style="list-style-type: none"> • All Queensland government departments • QRAIL • Anti-Discrimination Commission Queensland • Queensland Family and Child Commission 	23	
Service providers				
Queensland Primary Health Networks	3.1	<ul style="list-style-type: none"> • Northern Queensland • Western Queensland • Central Queensland, Wide Bay, Sunshine Coast • Darling Downs and West Moreton • Brisbane North • Brisbane South • Gold Coast 	7	
Hospital and Health Services	3.2	<ul style="list-style-type: none"> • Children's Health Queensland • Torres and Cape • Cairns and Hinterland • North West • Townsville • Mackay • Central West • Central Queensland • Wide Bay • South West • Darling Downs • Sunshine Coast • Metro North • Metro South • West Moreton • Gold Coast • Chair of HHS Board Chairs 	17	
Non-government alcohol and other drug organisations	3.3	Invited to complete Paxton Survey		
Specialist services	3.4	<ul style="list-style-type: none"> • Queensland Transcultural Mental Health Centre • Queensland Centre for perinatal and Infant Mental Health • Queensland Forensic Mental Health Service • Deafness and Mental Health Service • Eating Disorders Outreach Service 	5	
Community				
Consumer and carer representative organisations	4.1	Invited to complete Paxton survey		

Community managed organisations	4.2.1	Mental Health	4	ARAFMI
	4.2.2	<ul style="list-style-type: none"> Queensland Voice for Mental Health Inc. Association of Relatives and Friends of the Mentally Ill (ARAFMI) 		
	4.2.3	<ul style="list-style-type: none"> Drug Abuse Queensland Injectors Health Network 		
		Suicide		
		<ul style="list-style-type: none"> Roses in the Ocean 		
Neighbourhood centres	4.3	<ul style="list-style-type: none"> Acacia Ridge Community Centre Prospect Community Centre Nambour Community Centre Centacare South Burnett Marlin Coast Neighbourhood Centre 	5	
Commissioners in other jurisdictions				
Federal and state government commissioners/equivalents	5	<ul style="list-style-type: none"> Federal Government NSW WA VIC 	4	
Advocacy, workforce and research groups				
Advocacy, workforce and research groups	6	<ul style="list-style-type: none"> AISRAP RANZCP (Queensland Branch) Australian College of MH Nurses Multicultural DA LGBTIQ (AIDS Council) NDS (Queensland) Public Guardian Public Advocate Ethnic Communities Council University of Queensland – Institute of Social Science Research University Melbourne Royal Melbourne Institute of Technology 	12	
Unions				
Unions	7	<ul style="list-style-type: none"> Australian Medical Association Queensland Australian Salaried Medical Officers Federation Australian Services Union (Qld Branch) The Australian Workers' Union of Employees (Qld) Queensland Council of Unions Queensland Nurses Union Together Queensland United Voice (Formerly LHMU) 	8	
Total			108	

Appendix 4: Written submission template

- ✓ Please complete the template on behalf of your organisation based on your experience working with the QMHC, where possible please draw on the views of those with lived experience of mental health or substance misuse issues and their families, carers and support persons
- ✓ Please only complete the template for questions that are relevant to your relationship with the QMHC—please note NA next to those that are not applicable
- ✓ Please provide your answers in no more than one page per question and please note there is no provision to incorporate attachments
- ✓ Submissions are strictly confidential and will only be reviewed by the Public Service Commission (PSC) Review Team
- ✓ Please lodge submissions at QMHCReview@psc.qld.gov.au by 5pm **Friday 27 May**

Questions	What is the QMHC doing well to achieve reform?	Are there areas for improvement?	Do you have any suggestions?
Question 1 Overall Value and Effectiveness The QMHC seeks to add value to the people of Queensland by driving reform towards a more integrated, evidence based, recovery oriented mental health and substance misuse system.			
Questions	Provide examples of what the QMHC has done to progress these agendas for your organisation	Provide details of: a. success and/or b. barriers to success	
Question 2 Strategic Positioning The QMHC seeks to: <ol style="list-style-type: none"> a. drive reform down to the service provision level; and b. assist in fostering greater integration between government, non-government and the private sectors. 			
Question 3 Strategic Planning The Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019 seeks to improve mental health and limit harm associated with substance misuse.			

Questions	Provide examples of what the QMHC has done to progress these agendas for your organisation	Provide details of: a. success and/or b. barriers to success
<p>Question 4 Review, Research and Report The QMHC Review, Research and Report (RRR) function is charged to enhance service delivery practices and benefit consumers.</p>		
<p>Question 5 Promotion and Awareness The QMHC Promotion and Awareness (PA) function is charged to support and promote prevention and early intervention to enhance general health and wellbeing of people with mental illness, substance misuse, their families, carers and support persons.</p>		
<p>Question 6 Systemic Governance The QMHC seeks to take into account individuals with multi-faceted and complex needs such as disability, chronic disease, homelessness, mental health and alcohol and substance misuse, and involvement with the criminal justice system.</p>		
<p>Question 7 Customer Focus The QMHC seeks to engage, consult and take into account the views, needs and vulnerabilities of different sections of the Queensland community.</p>		
<p>Question 8 Collaboration The QMHC seeks to generate common, inter-sectoral ownership and genuine collaboration on the development and implementation of strategies with partners and providers.</p>		

Appendix 5: Summary of 2016 Paxton Partners survey respondents

The annual QMHC Independent Evaluation Survey is the main information source contributing to an understanding of impacts and improvements made by the QMHC over time. As the name suggests, it is administered annually to all stakeholders that have engaged with the QMHC, in one form or another, in the preceding year. The survey therefore captures a mixture of new respondents as well as those who completed preceding surveys.

The PSC invited a wider group of stakeholders to provide written submissions to their review and included the opportunity for these stakeholders to also respond to the 2016 Evaluation Survey.

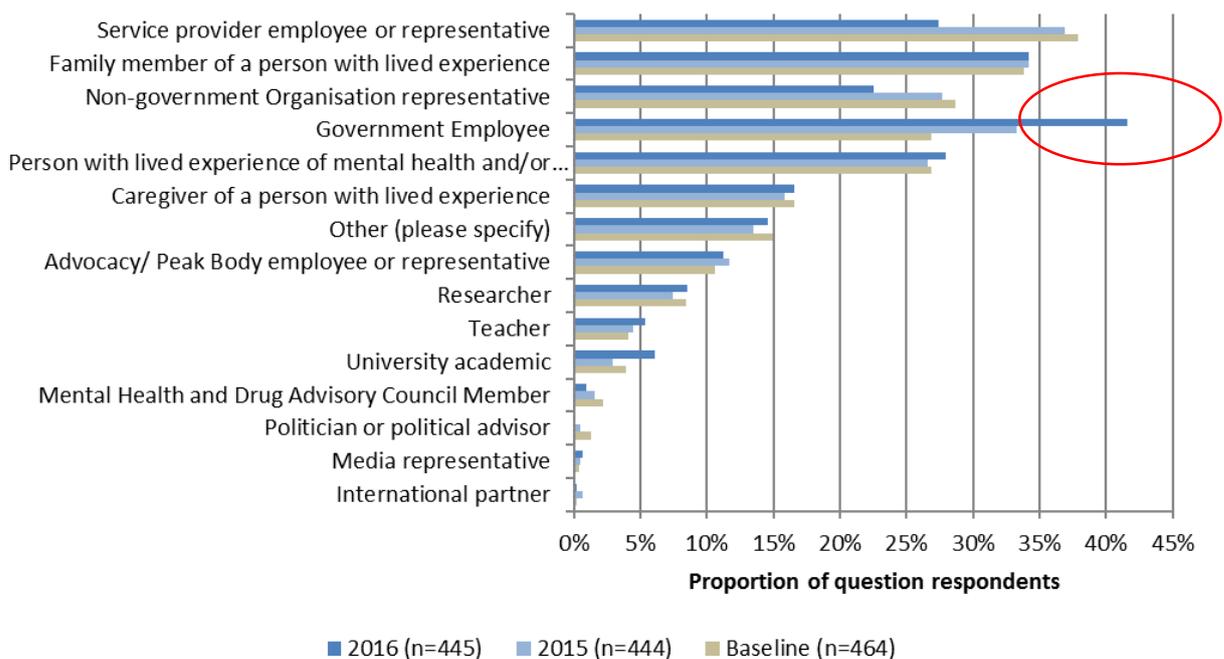
The survey consists of a set of standard questions that are repeated year-on-year to allow direct comparison and trending of results. In addition to the standard questions, the survey is augmented in any given year, by a specific series of questions focusing on a key topic of interest. For example, the 2015 Survey included an additional set of questions dedicated to understanding stakeholder perceptions of the Strategic Plan, which had been completed and released subsequent to the initial survey and Baseline Report.

In the current 2016 survey, specific questions were added to focus on the stakeholder perceptions of the QMHC’s promotion and awareness activities and also its effectiveness at collaborating with key stakeholders in the mental health, drug and alcohol sectors.

Note: Few survey questions were compulsory and therefore a different number of the total survey respondents answered each question. As such, when referring to “Proportion of respondents” in the graphs and text throughout this report, this refers to the proportion of respondents to the specific question being presented and never the overall survey respondents. The number of respondents to each specific question is noted as an ‘n’ value on each graph for reference.

The sub-section below (Figure 4) presents a high-level comparison of the profiles of survey respondents over time.

Figure 4: Paxton Survey - Role of survey respondents



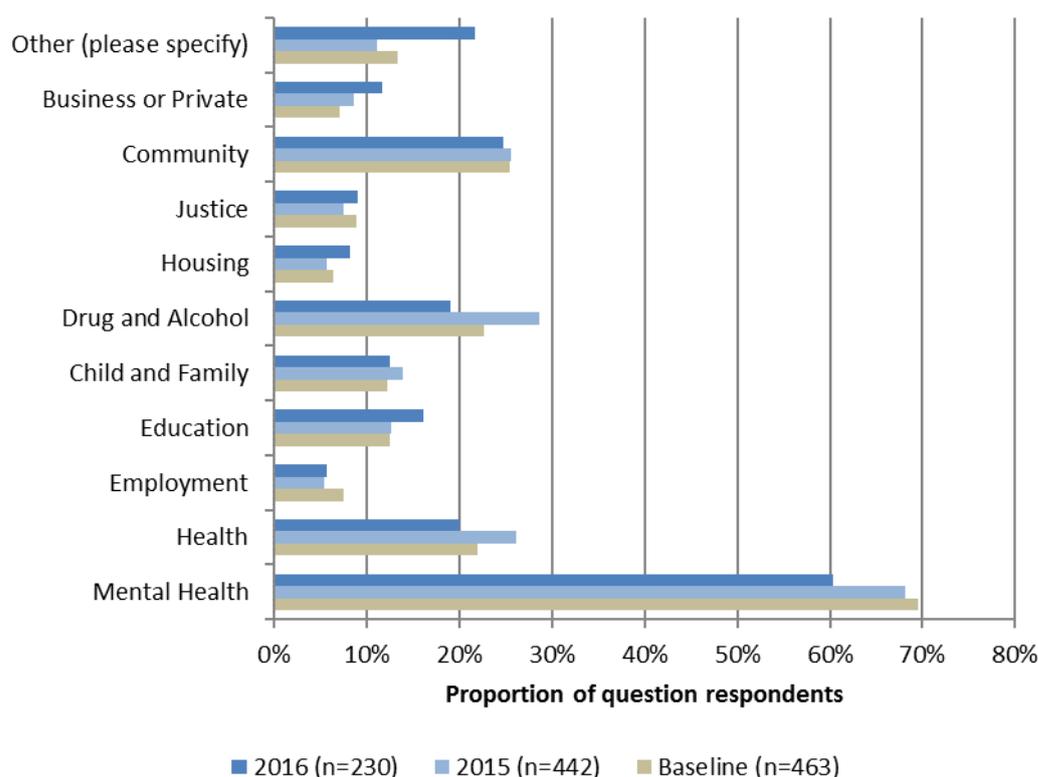
Of the 199 respondents in 2016 providing a valid response (Table 6), the largest proportions reported being employed by the Department of Health (almost 30%), HHSs (~24%) or QPS (~20%). This change is most likely attributed at least in part to the request for the PSC to all departments to participate.

Table 6: Paxton Survey - Queensland state government respondents

QLD State Government Department and Statutory Bodies	Respondents	Proportion
Department of Health (including eHealth Queensland and Health Support Services)	58	29.1%
Hospital or Health Service	47	23.6%
Queensland Police Service	39	19.6%
Department of Education and Training	15	7.5%
Department of Justice and Attorney-General	9	4.5%
Department of Housing and Public Works	5	2.5%
Department of Communities, Child Safety and Disability Services	5	2.5%
Queensland Treasury	4	2.0%
Anti-Discrimination Commission Queensland	3	1.5%
Department of Aboriginal and Torres Strait Islander Partnerships	3	1.5%
Legal Aid Queensland	2	1.0%
Department of State Development, Infrastructure and Planning	2	1.0%
Queensland Rail	2	1.0%
Public Service Commission	1	0.5%
Queensland Family and Child Commission	1	0.5%
Department of Natural Resources and Mines	1	0.5%
Queensland Mental Health Commission	1	0.5%
Department of Science, Information Technology and Innovation	1	0.5%
Total	199	100.00%

Most sectors within Queensland were represented in the survey results (Figure 5), although the Mental Health sector dominated, comprising ~60-70% of respondents across all years. Less than 10% of respondents identified as representing Justice, Employment, Business or private, or Housing.

Figure 5: Paxton Survey - Sectors represented by survey respondents



Approximately a quarter of all respondents to each survey identified as representing one or more priority populations. Table 7 presents the proportion of overall survey respondents, across years, that identified with each priority population group, as compared to the indicative Queensland population rates.

Table 7: Paxton Survey - Survey respondents representing priority populations²⁸

Priority population groups	2014 (n=453)	2015 (n=433)	2016 (n=431)	Indicative QLD population rates	Source
Aboriginal and/or Torres Strait Islander background (ATSI)	6%	8%	6%	3.6%	2011 Census QLD Figures
Culturally and linguistically diverse (CALD)	7%	6%	6%	20.5%	2011 Census QLD Figures
Person with a disability	9%	7%	9%	17.7%	2012 Survey Disability Ageing and Carers ABS
Person experiencing both mental health difficulties and issues related to substance use	6%	6%	8%	N/A	
Lesbian, gay, bisexual, transgender and intersex (LGBTI)	5%	6%	5%	N/A	

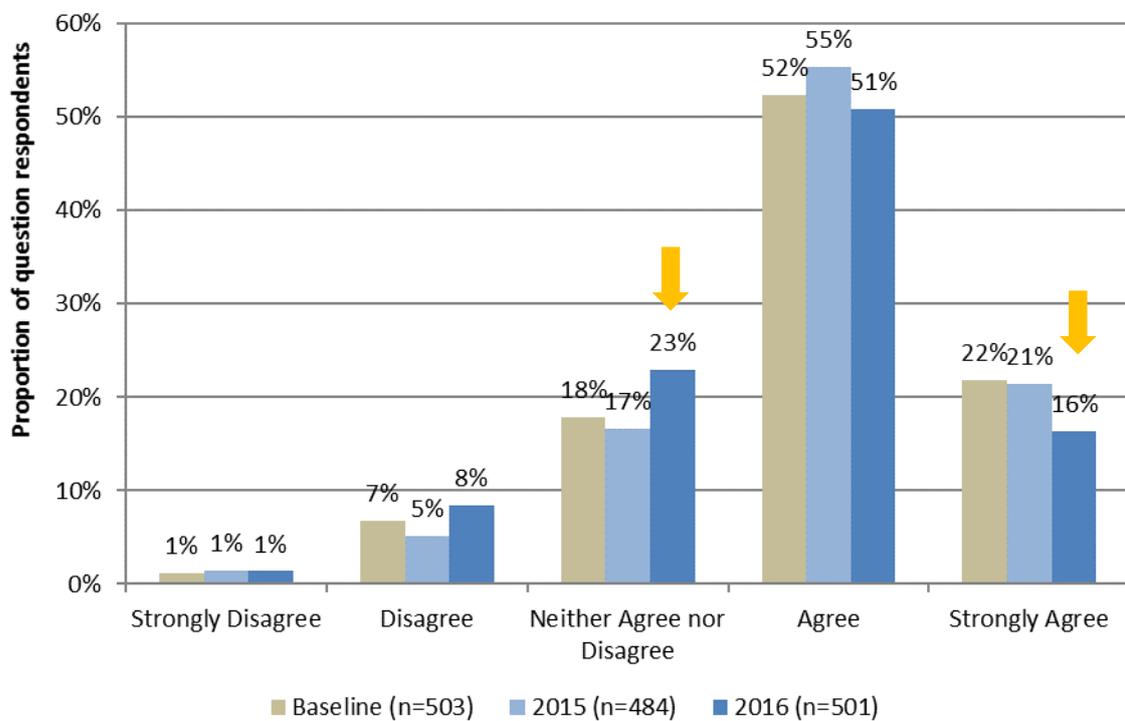
N/A = no reliable source of Queensland population data exists for these groups

²⁸ Groups were mutually exclusive – respondents could select more than one group

Important to the quality of the survey results, is respondents' perceived knowledge of the Queensland mental health, drug and alcohol system. Approximately three quarters of respondents, at both the Baseline and 2015 surveys, strongly agreed (~20%) or agreed (~50%) that they felt knowledgeable about the mental health, drug and alcohol system in QLD (Figure 3). In 2016, the proportion of respondents that strongly agreed reduced slightly to 16%, while the proportion neither agreeing nor disagreeing increased to 23%. Less than 10% of respondents, in all surveys disagreed.

Overall, this may suggest a slight shift in 2016 towards respondents who are less knowledgeable about the mental health, drug and alcohol system in Queensland. This may in turn be reflective of the wider distribution of the 2016 survey to stakeholders beyond representatives from health/mental health at the request of the PSC and will need to be taken into account when interpreting trends.

Figure 6: Paxton Survey - "I feel knowledgeable about the mental health, drug and alcohol system in Queensland"



Appendix 6: Paxton Partners, QMHC June 2016 annual survey (interim report)



PAXTON PARTNERS

Queensland Mental Health Commission
Evaluation Methodology Development
2016 Annual Survey - Interim Report
June 2016

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Disclaimer:

This report is prepared solely for the purpose set out in Section 1.1 and is not to be used for any other purpose without Paxton Partners’ and the QMHC’s prior written consent.

The report includes references to the views of various QMHC stakeholders. Paxton Partners has relied on direct feedback from stakeholders or the results of surveys in reporting such views. Where possible, the broader representativeness of such views is indicated. However, Paxton Partners has not sought to further validate these views beyond the scope of the activities described in Section 2.

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Acknowledgement

Paxton Partners would like to thank expressly all those who responded to the evaluation survey. This input is critical to the evaluation and the improvement of the QMHC to what should be the ultimate benefit of consumers, families and carers who rely on Queensland’s mental health, alcohol and other drugs service system.

1. Evaluation Overview

1.1 Purpose of this report

The purpose of this report is to provide input into the independent review of the Queensland Mental Health Commission (referred to as “QMHC” or “the Commission” throughout this report) being undertaken by the Queensland Public Service Commission (PSC), as part of the legislated requirement for the QMHC to undergo an independent review of its performance within 3 years¹.

In working towards this goal, the PSC review had the following objective:

- To confirm the QMHC is operating effectively in terms of its function, in the performance of its identified functions (as defined in S.11 of the Act); and to satisfy the legislative requirement for a review to take place, with recommendations to the Minister by 30 June 2016.

The review provided an opportunity for a point in time assessment of the performance/effectiveness of QMHC delivery of functions as defined under the Act. The review was future focused to provide guidance on future priorities based on the review assessment.

The report provides an **interim update** on the results of the 3rd annual QMHC Evaluation survey, with a particular focus on the QMHC’s performance with respect to collaboration with stakeholders across the Mental Health, Drug and Alcohol sectors in Queensland.

Further analysis of the full evaluation survey results will be presented separately in the Stage 3 QMHC Evaluation Report.

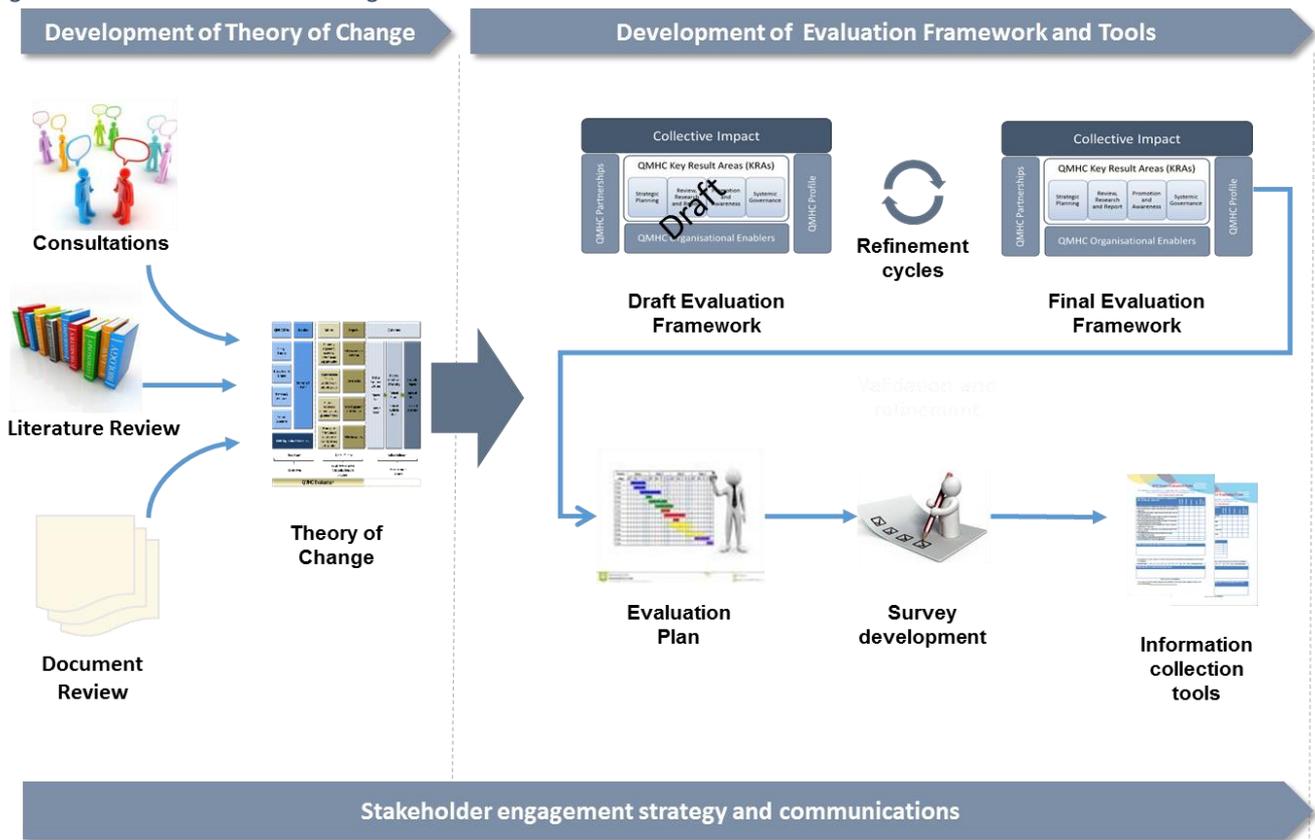
1.2 Overview of evaluation design

The design of the QMHC Evaluation was underpinned by the development of a Theory of Change (see Appendix A – QMHC Evaluation Logic Model) informed by an extensive Literature Review², stakeholder consultations and review of QMHC documentation. This Theory of Change served as the reference point against which to develop the Evaluation Framework that defines the key evaluation domains and questions. The Evaluation Framework informed the development of the Evaluation Plan, articulating the practical evaluation activities, and the Evaluation Tools for use in collecting the required evaluative information.

¹ *Queensland Mental Health Commission Act 2013*, Part 7, s55

² The full Literature Review is available here: <http://www.qmhc.qld.gov.au/about-us/our-performance/performance-framework/>, accessed 19 August 2015

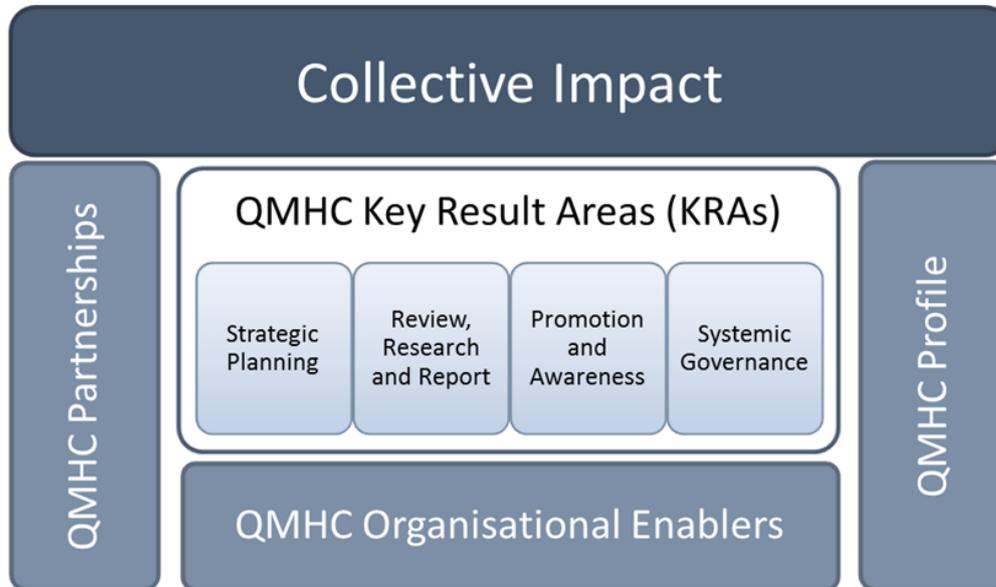
Figure 1: Overview of Evaluation Design Activities



1.2.1 Evaluation Framework

The QMHC Evaluation Framework (Figure 2) was designed to test the linkages depicted in the Theory of Change and the QMHC’s activities, achievement, or contribution to achievement, of the anticipated impacts and outcomes.

Figure 2: QMHC Evaluation Framework



The framework is comprised of five inter-related domains:

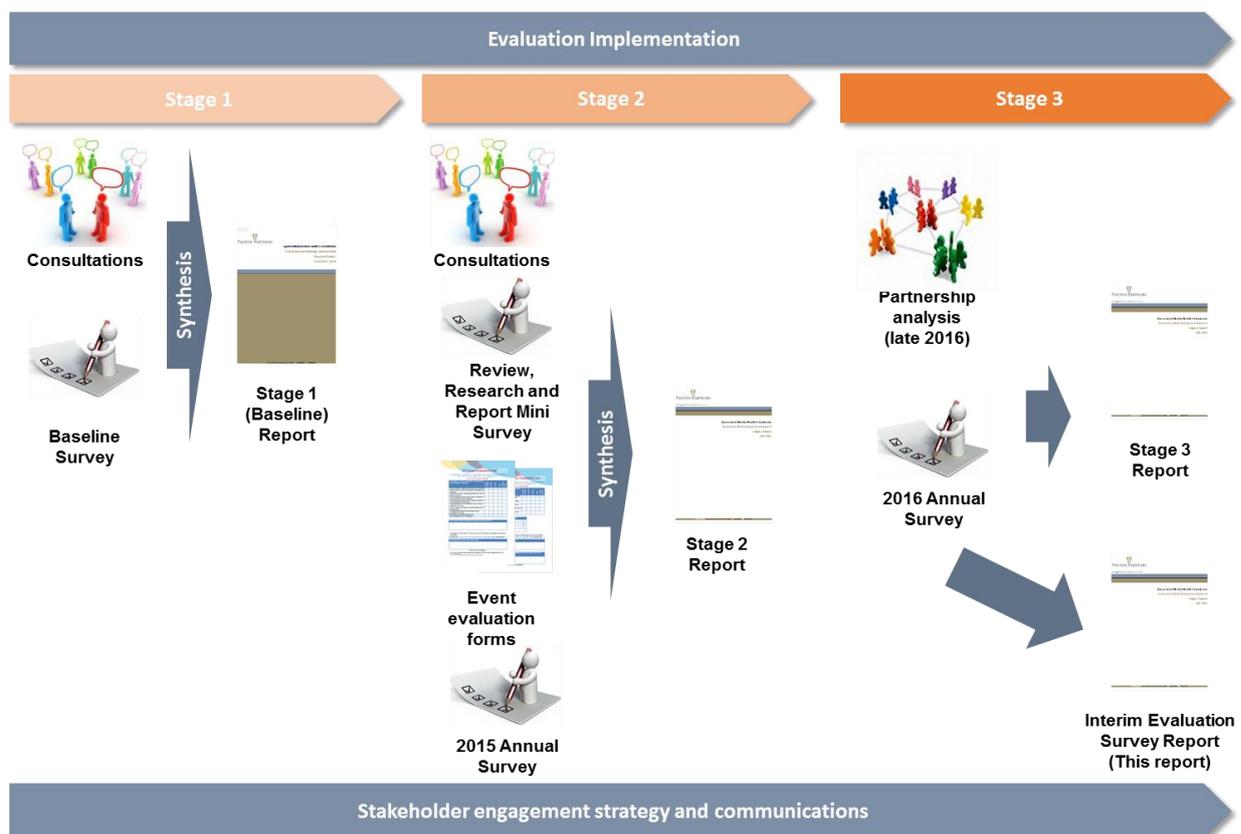
1. **QMHC Organisational Enablers** explores the systems, processes and infrastructure of the Commission to support the inter-related components.
2. The **QMHC Partnerships** component focuses on the Commission’s ability to develop effective and sustainable partnerships at multiple stakeholder levels, required to support its other activities.
3. The **QMHC Profile** component focuses on assessing the effectiveness of the Commission’s communication and engagement activities.
4. **QMHC Key Result Areas (KRAs)** consider the Commission’s performance against each of its stated functions.
5. The **Collective Impact** component focuses on longer-term indicators related to consumer and system outcomes.

2. Evaluation activities to date

2.1 Overview

Implementation of the QMHC Evaluation was split broadly into three stages:

- **Stage 1³ (2013/14):** Development of a Baseline Report for the performance of the QMHC, involving targeted consultation with a broad range of QMHC stakeholders across Queensland (QLD) and a comprehensive Baseline Survey.
- **Stage 2 (2014/15):** Assessment of the performance of the QMHC, based on its activities for the year following the Baseline Report findings. Stage 2 focused particularly on evaluating the development and release of *Queensland Mental Health, Drug and Alcohol Strategic Plan (2014 – 2019)* (the ‘Strategic Plan’) and an analysis of the Review, Research and Report Key Result Area.
- **Stage 3 (2015/16):** The current stage seeks to understand the QMHC’s overall performance over its first three years of operation and progress towards the achievement of benefits and impacts for Mental Health, Alcohol and Drug service consumers, their families and carers. In particular, this stage focuses the QMHC’s impact on improving collaboration within the QLD Mental Health, Alcohol and Other Drugs service sectors, and with other related sectors, as collaboration serves as a key mechanism to achieve collective impacts.



³ Results from Stage 1 are reported in the QMHC Evaluation Baseline Report available here: <http://www.qmhc.qld.gov.au/about-us/our-performance/2014-survey/full-2014-performance-report/>, accessed 20 July 2015

2.2 Annual survey overview

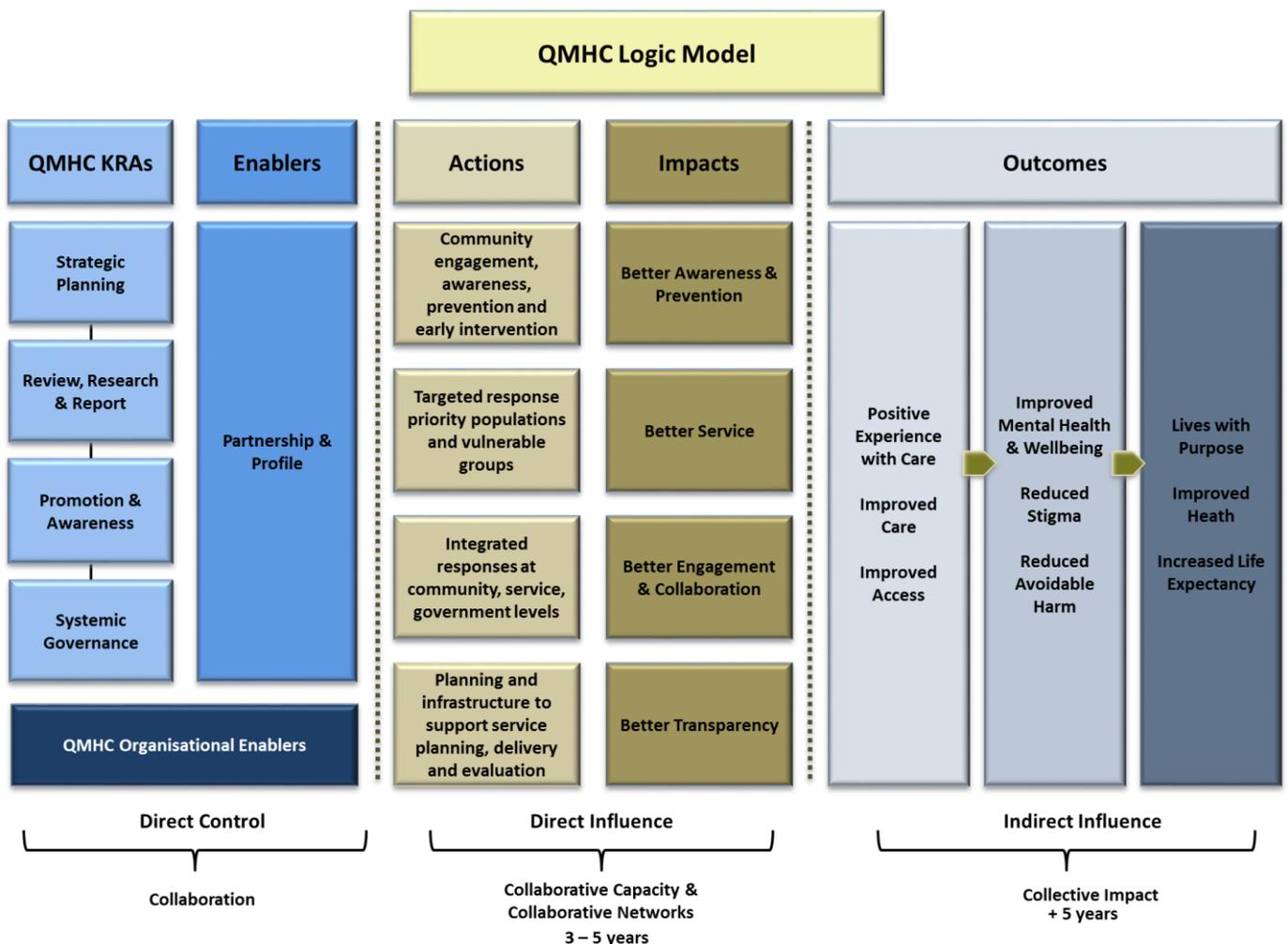
The annual QMHC Evaluation Survey formed the main information source contributing to an understanding of impacts and improvements made by the QMHC over time. As the name suggests, it was administered annually to stakeholders that had engaged with the QMHC, in one form or another, in the preceding year. The survey therefore captures a mixture of new respondents as well as those who completed prior year surveys.

The PSC invited a wider group of stakeholders to provide written submissions to their review and included the opportunity for these stakeholders to also respond to the 2016 Evaluation Survey.

The survey consists of a set of standard questions that are repeated year-on-year to allow direct comparison and trending of results. In addition to the standard questions, the survey was augmented year-on-year, by the inclusion of a specific series of questions focusing on a key topic of interest. For example, the 2015 Survey included an additional set of questions dedicated to understanding stakeholder perceptions of the Strategic Plan, which had been completed and released subsequent to the initial survey and Baseline Report.

In the current 2016 survey, specific questions were added to focus on stakeholder perceptions of the QMHC’s promotion and awareness activities and also its effectiveness at collaborating with key stakeholders in the mental health, drug and alcohol sectors (see Appendix A – QMHC Evaluation Logic Model)

Note: Few survey questions were compulsory and therefore a different number of the total survey respondents answered each question. As such, when referring to “Proportion of respondents” in the graphs and text throughout this report, this refers to the proportion of respondents to the specific question being presented and never the overall survey respondents. The number of respondents to each specific question is noted as an ‘n’ value on each graph for reference.



Appendix B – 2016 Survey questions).

The sub-section below presents a high-level comparison of the profiles of survey respondents over time.

2.2.1 Profile of Survey Respondents

Of the survey respondents over time that provided a valid postcode (~74%-80% of total respondents), the majority (96-98%) of those providing a valid postcode) indicated as being in Queensland.

Figure 3 displays the percentage of Queensland respondents from each remoteness area classification, as compared to the distribution of the overall Queensland population. This demonstrates that the mix of survey respondents approximately mirrored to the Queensland population distribution. However, the Outer Regional areas still appear under-represented compared to the Queensland population. This finding is consistent with the responses in the 2015 survey in which there was a clear theme that the QMHC must improve engagement with regional and remote areas in Queensland.

For certain questions throughout this report, results are presented according to rurality to identify any differences in respondent opinion based on the rurality of their location.

Figure 3: Survey respondents by remoteness

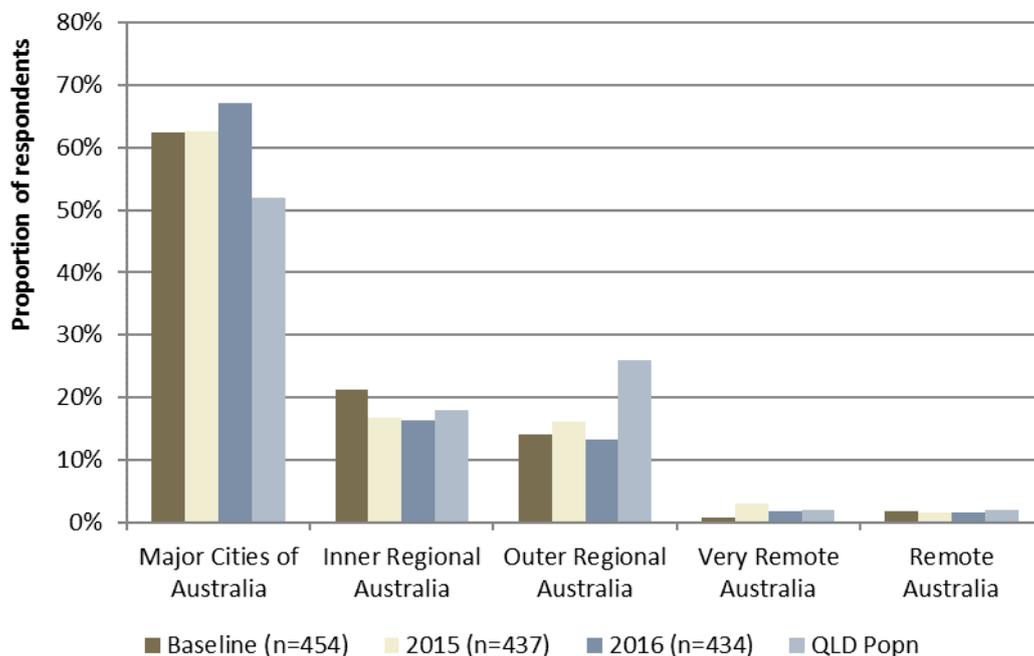
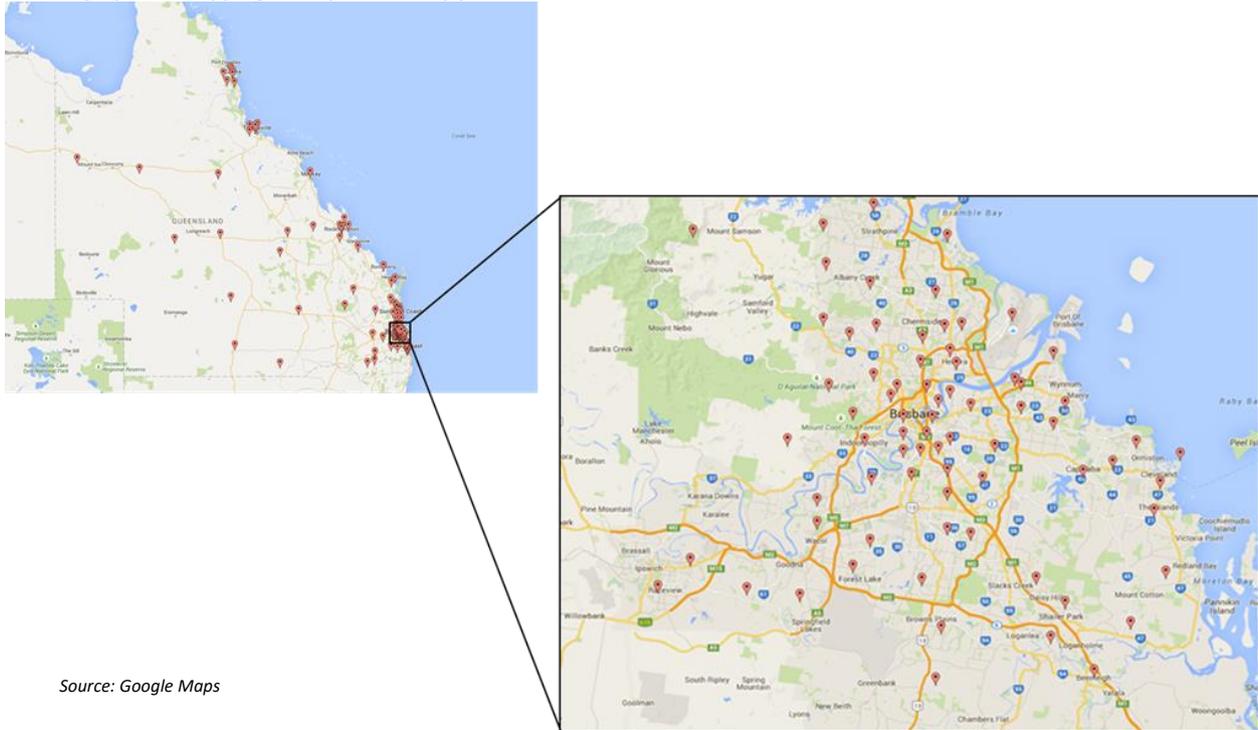


Figure 4 is a graphical map depicting the location of 2016 survey respondents by postcode. Unsurprisingly, the majority of respondents were clustered in Queensland, specifically around Brisbane. However, some respondents indicated their postcode as originating in New South Wales (NSW), Victoria or West Australia (WA).

Figure 4: Geographical mapping of respondents by postcode

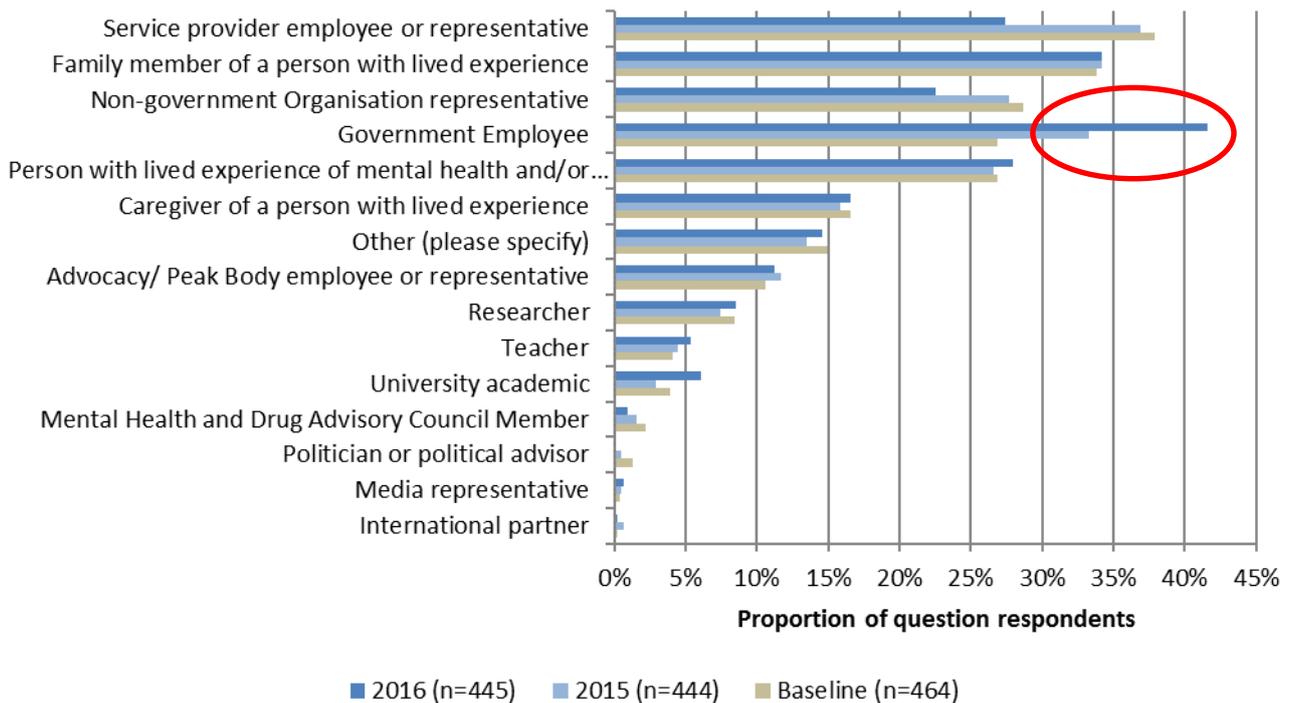


Source: Google Maps

Respondents represented a variety of roles in the community (Figure 5). The largest proportion of respondents identified as employees or representatives of service providers, while similarly high proportions were family members of a person with lived experience. Consistent with previous years, just over a quarter of respondents to the 2016 survey were people with lived experience of mental health and/or substance misuse issues. The largest single increase in respondent group over time (approximately 25% year on year growth) was for respondents identifying as government employees, with 42% of 2016 survey respondents identifying as government employees. The growth in government employees in the current year is likely due to the parallel review activities being undertaken by the PSC.

Approximately, 15% of respondents identified as 'Other' in each survey; there was no trend amongst these responses, which included clinicians, volunteers, parents, researchers, individual advocates, and representatives of small grass-roots organisations.

Figure 5: Role of survey respondents



In the 2016 survey, a new question invited state government employees to identify the Queensland state government department or statutory body they are employed by. Of the 199 respondents providing a valid response, the largest proportions reported being employed by the Department of Health (~30%), Hospital or Health Services (~24%) or Queensland Police Service (~20%).

Table 1: Queensland State Government Respondents

QLD State Government Department and Statutory Bodies	Respondents	Proportion
Department of Health (including eHealth Queensland and Health Support Services)	58	29.1%
Hospital or Health Service	47	23.6%
Queensland Police Service	39	19.6%
Department of Education and Training	15	7.5%
Department of Justice and Attorney-General	9	4.5%
Department of Housing and Public Works	5	2.5%
Department of Communities, Child Safety and Disability Services	5	2.5%
Queensland Treasury	4	2.0%
Anti-Discrimination Commission Queensland	3	1.5%
Department of Aboriginal and Torres Strait Islander Partnerships	3	1.5%
Legal Aid Queensland	2	1.0%
Department of State Development, Infrastructure and Planning	2	1.0%
Queensland Rail	2	1.0%
Public Service Commission	1	0.5%
Queensland Family and Child Commission	1	0.5%
Department of Natural Resources and Mines	1	0.5%
Queensland Mental Health Commission	1	0.5%
Department of Science, Information Technology and Innovation	1	0.5%
Total	199	100.00%

Most sectors within Queensland were represented in the survey results (Figure 6), although the Mental Health sector dominated, comprising ~60-70% of respondents across all years. Less than 10% of respondents identified as representing Justice, Employment, Business or private, or Housing. This may suggest a need for the QMHC to

improve its engagement with these sectors given the intersection between these sectors and mental health. However, this may also likely be reflective of the lower relative number of survey invitees representing these sectors.

There was an increase in the proportion of 2016 respondents selecting the ‘Other’ category (13% in 2015; 22% in 2016) respondents and contained a range of responses including disability, Primary Healthcare, suicide support, youth, aged care and volunteers.

It should be noted that there was a substantial decline in the total number of 2016 respondents (230) identifying their sector compared to prior years (Baseline: 463; 2015: 442). This is likely due to the addition in 2016 of the separate question requesting state government employees to identify the department or statutory body they are employed by (see Table 1).

Figure 6: Sectors represented by survey respondents

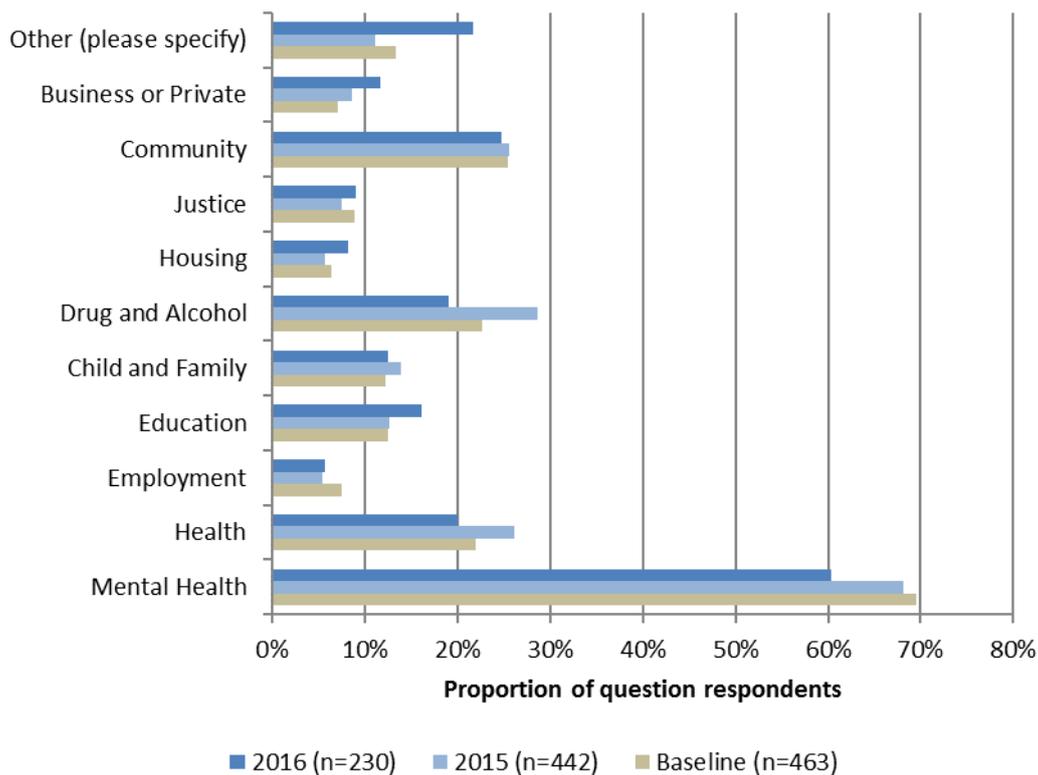
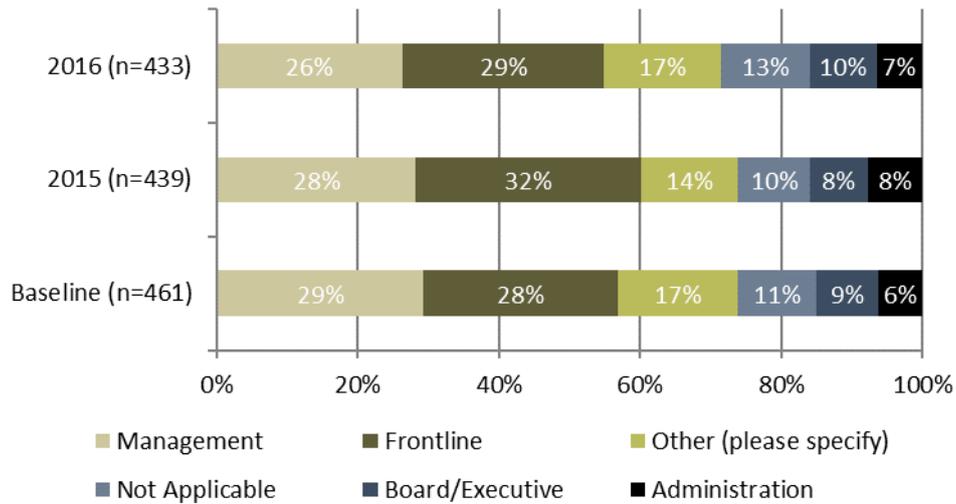


Figure 7 shows that respondents held a variety of positions within their organisation (where applicable). These results provide an insight into the levels at which the QMHC is interacting. The profile of respondent position was similar across all years. Management and Frontline staff were represented in almost equivalent proportions across all years. Administration and Board/Executive respondents collectively made up between 15% and 17% of respondents in each year.

Figure 7: Positions of survey respondents



Approximately a quarter of all respondents to each survey identified as representing one or more priority populations. Table 2 presents the proportion of overall survey respondents, across years, that identified with each priority population group, as compared to the indicative Queensland population rates.

Table 2: Survey respondents representing priority populations⁴

Priority population groups	2014 (n=453)	2015 (n=433)	2016 (n= 431)	Indicative QLD population rates	Source
Aboriginal and/or Torres Strait Islander background (ATSI)	6%	8%	6%	3.6%	2011 Census QLD Figures
Culturally and linguistically diverse (CALD)	7%	6%	6%	20.5%	2011 Census QLD Figures
Person with a disability	9%	7%	9%	17.7%	2012 Survey Disability Ageing and Carers ABS
Person experiencing both mental health difficulties and issues related to substance use	6%	6%	8%	N/A	
Lesbian, gay, bisexual, transgender and intersex (LGBTI)	5%	6%	5%	N/A	

N/A = no reliable source of Queensland population data exists for these groups

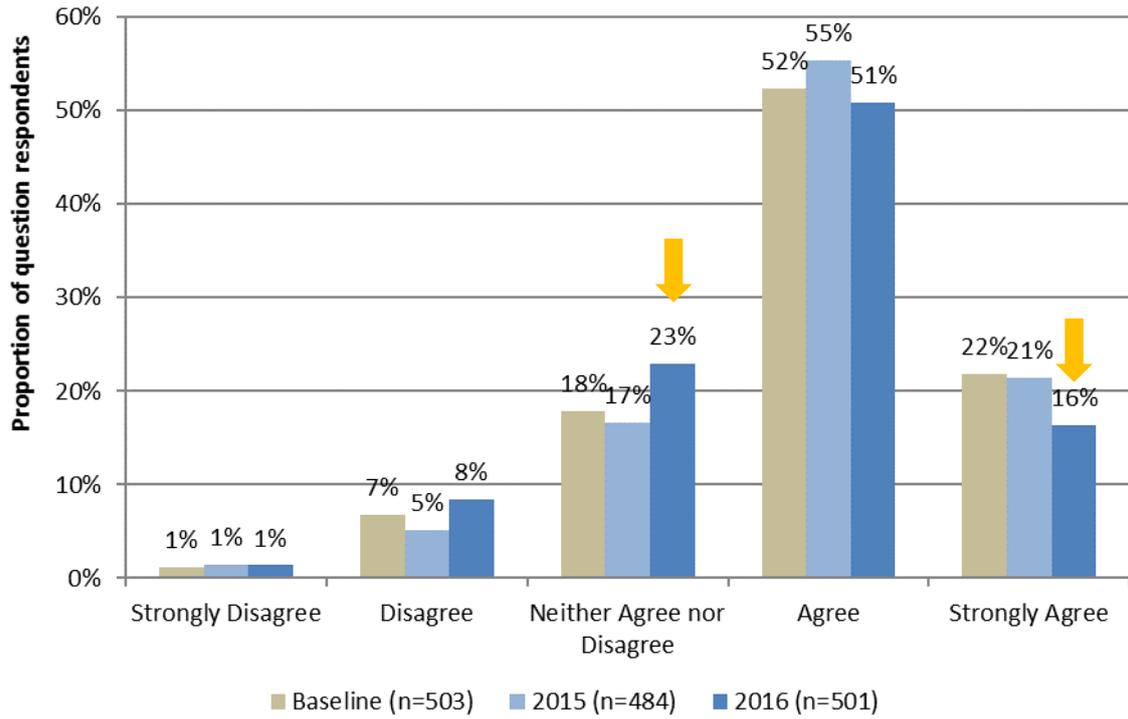
These results suggest that the proportion of survey respondents representing people with Aboriginal and/or Torres Strait Islander backgrounds was approximately typically around double that of the proportion expected based on the QLD population. Conversely, people with CALD backgrounds and those with a disability were considerably under-represented in across all years, as compared to the proportions expected in the broader QLD population.

Important to the quality of the survey results, is respondents' perceived knowledge of the QLD mental health, drug and alcohol system. Approximately three quarters of respondents, at both the Baseline and 2015 surveys, strongly agreed (~20%) or agreed (~50%) that they felt knowledgeable about the mental health, drug and alcohol system in QLD (Figure 8). In 2016, the proportion of respondents that strongly agreed reduced slightly to 16%, while the proportion neither agreeing nor disagreeing increased to 23%. Less than 10% of respondents, in all surveys disagreed.

Overall, this may suggest a slight shift in 2016 towards respondents who are less knowledgeable about the mental health, drug and alcohol system in QLD. This may in turn be reflective of the wider distribution of the 2016 survey to stakeholders beyond representatives from health/mental health.

⁴ Groups were mutually exclusive – respondents could select more than one group.

Figure 8: “I feel knowledgeable about the mental health, drug and alcohol system in QLD”



3. Interim survey results

This section describes the key findings from the interim extraction of QMHC Evaluation survey data. The findings are organised to align to the major components of the PSC review:

- Strategic Positioning
- Key Result Areas:
 - Strategic Planning
 - Review, Research and Report
 - Promotion and Awareness
 - Systemic Governance
- Customer Focus, and
- Collaboration.

3.1 Overall QMHC value

This section presents the survey results related to stakeholder perceptions of the overall value of the QMHC. Over the last three years, an increasing proportion of QMHC survey respondents indicated that, in overall terms, positive reform of the mental health, drug and alcohol sectors, is underway (Figure 9). In 2016, this proportion has increased to almost two-thirds of survey respondents.

Figure 9: “Overall, there is positive reform underway” – over time



When breaking this result down by role (Figure 10) these proportions remained similar, with a few exceptions. Slightly higher proportions of service providers and NGOs reported agreeing that positive reform was underway (74% and 79%, respectively), while the lowest agreement was found with researchers and teachers (58% and 52%, respectively).

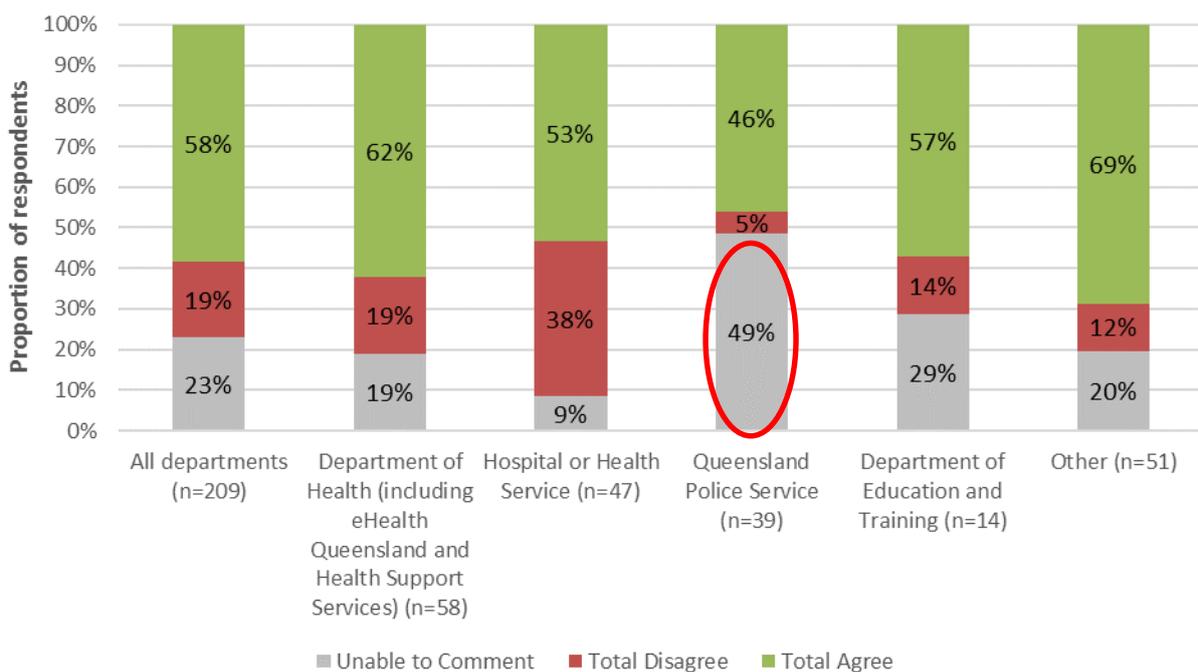
Figure 10: “Overall, there is positive reform underway” – by role



When viewed by Queensland state government department, the Department of Health had the highest proportion of respondents agreeing that positive reform is underway (62%). In contrast, respondents from hospitals or health services were the most likely to disagree that positive reform is underway (38%). This is consistent with the fact that translation from strategy to action ‘on the ground’ takes additional time and/or may be more difficult to observe.

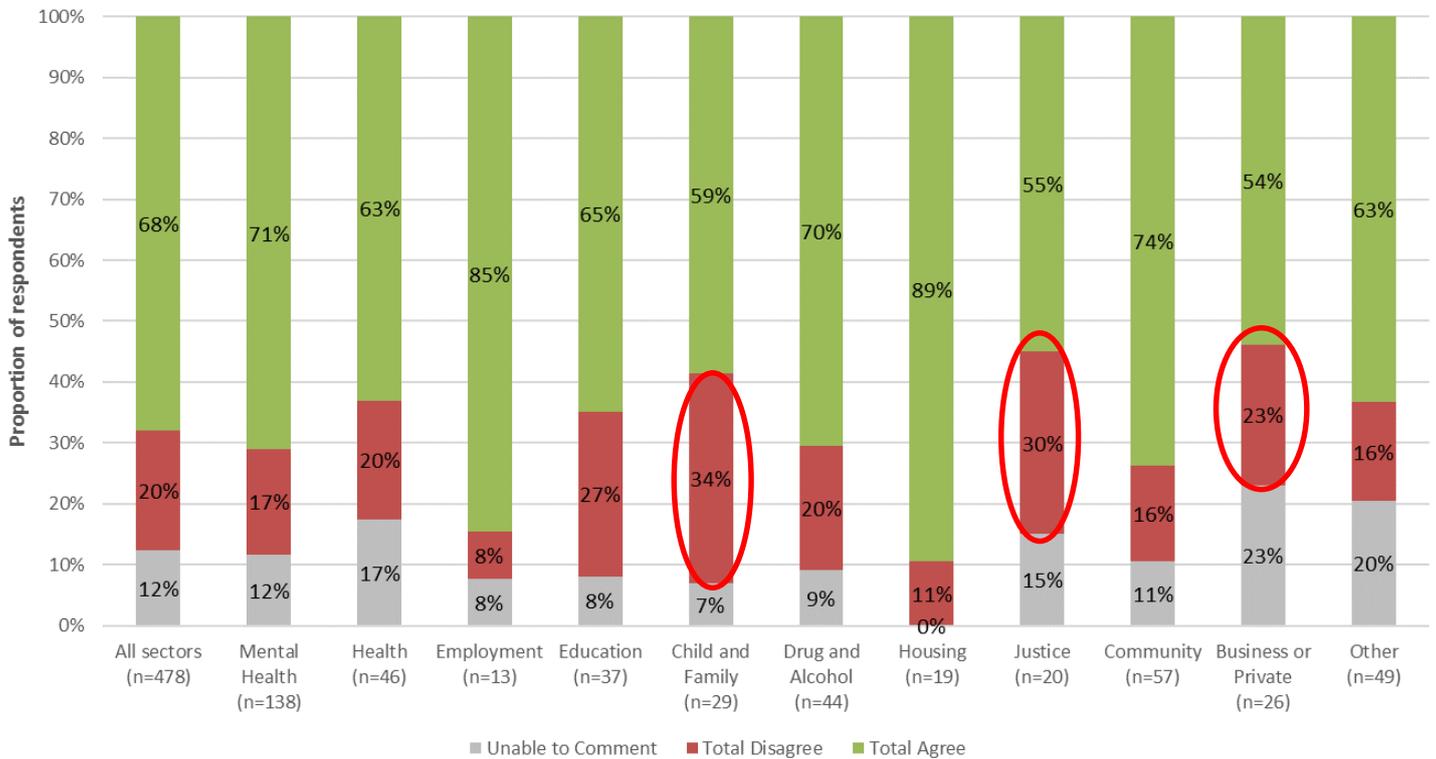
Almost half of all respondents identifying as Queensland Police Service employees reported being unable to comment on the question, suggesting that these respondents may be less aware of reforms in the mental health, drug and alcohol system.

Figure 11: “Overall, there is positive reform underway” – by department



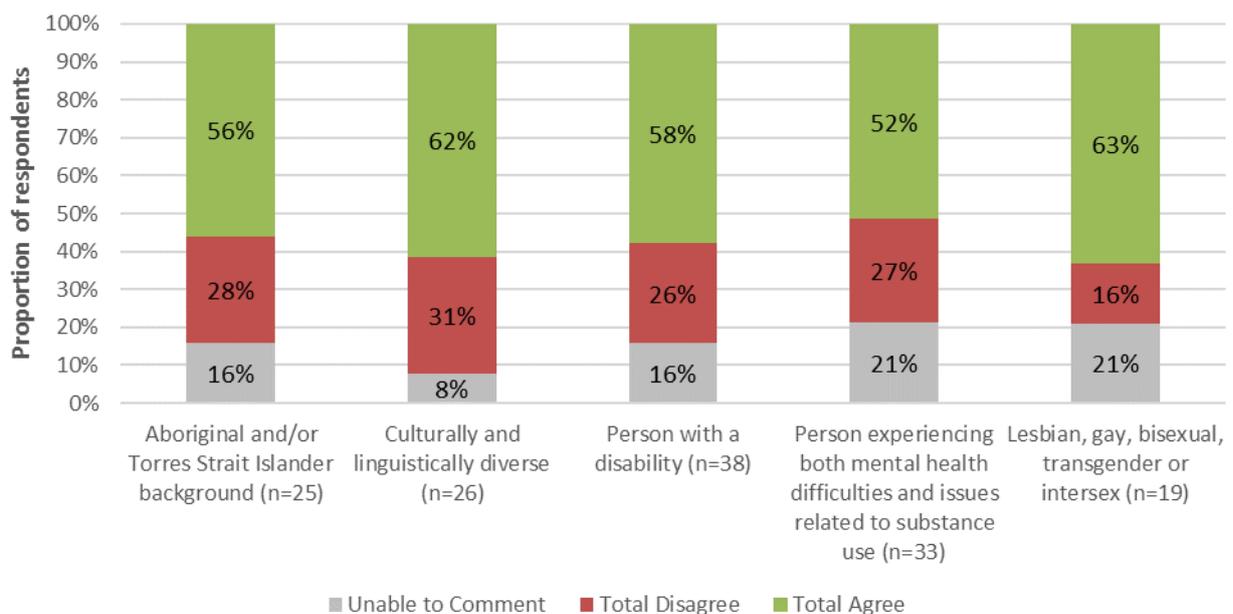
Encouragingly, the majority of respondents across all sectors agreed that positive reform is underway (ranging from 89% - “Housing” to 54% - “Business or private”). The largest proportions disagreeing with the statement were observed for respondents from Child and Family (34%), Justice (30%) and Business or Private (23%), suggesting that better engagement and/or more collaborative work may be needed with these sectors.

Figure 12: “Overall, there is positive reform underway” – by sector



While small overall volumes, the majority of respondents identifying with one or more priority population also agreed that positive reform is underway (ranging from 52% to 63%).

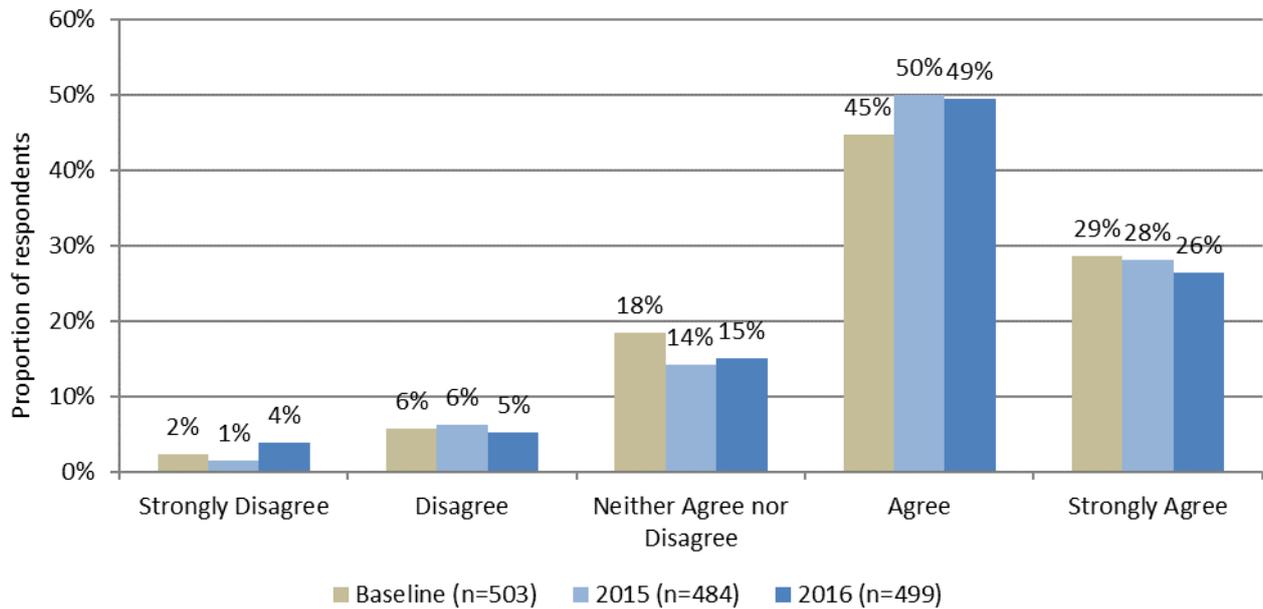
Figure 13: “Overall, there is positive reform underway” – by priority population



3.2 Strategic Positioning

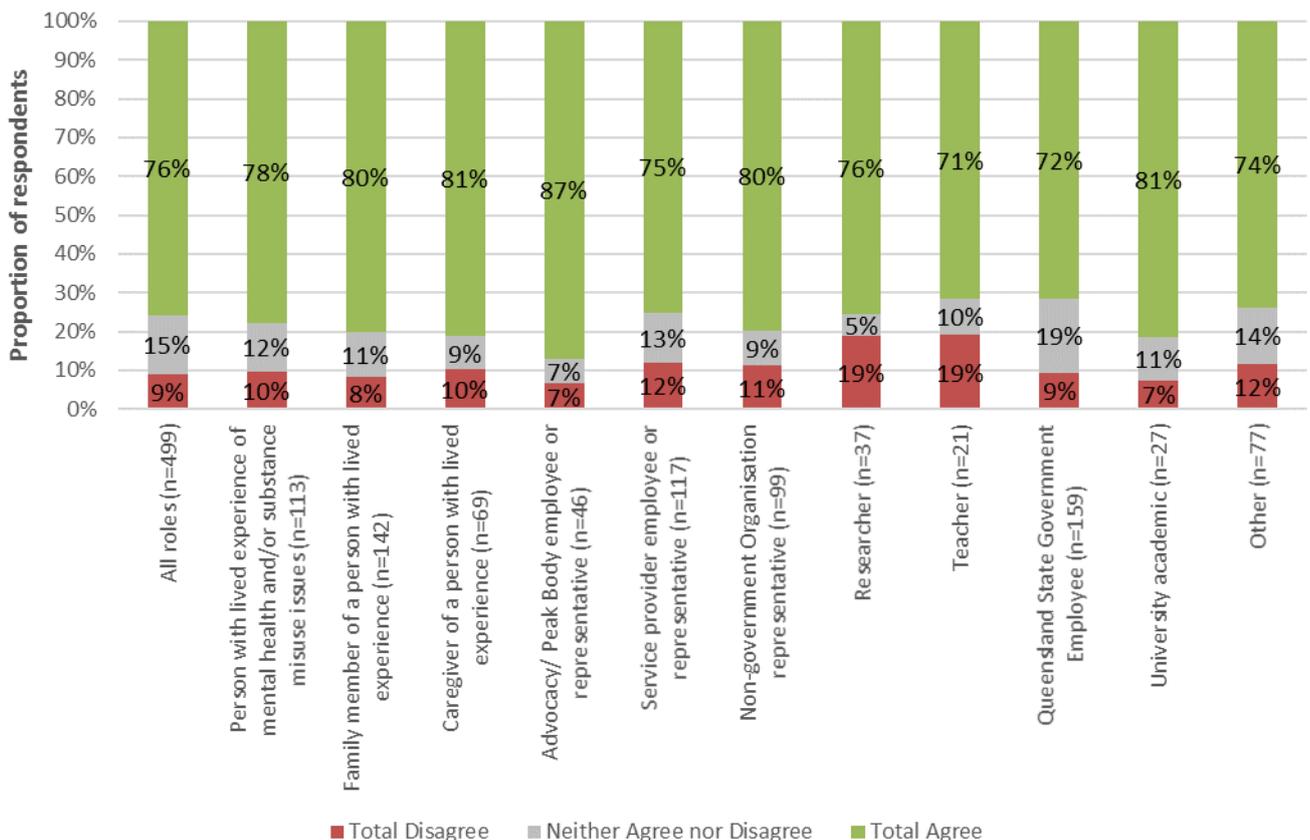
In each year, approximately three quarters of survey respondents reported agreeing that they view the QMHC as an important driver of reform of the mental health, drug and alcohol system in QLD (Figure 14).

Figure 14: "I view the QMHC as an important driver of reform of the mental health, drug and alcohol system in QLD." – over time



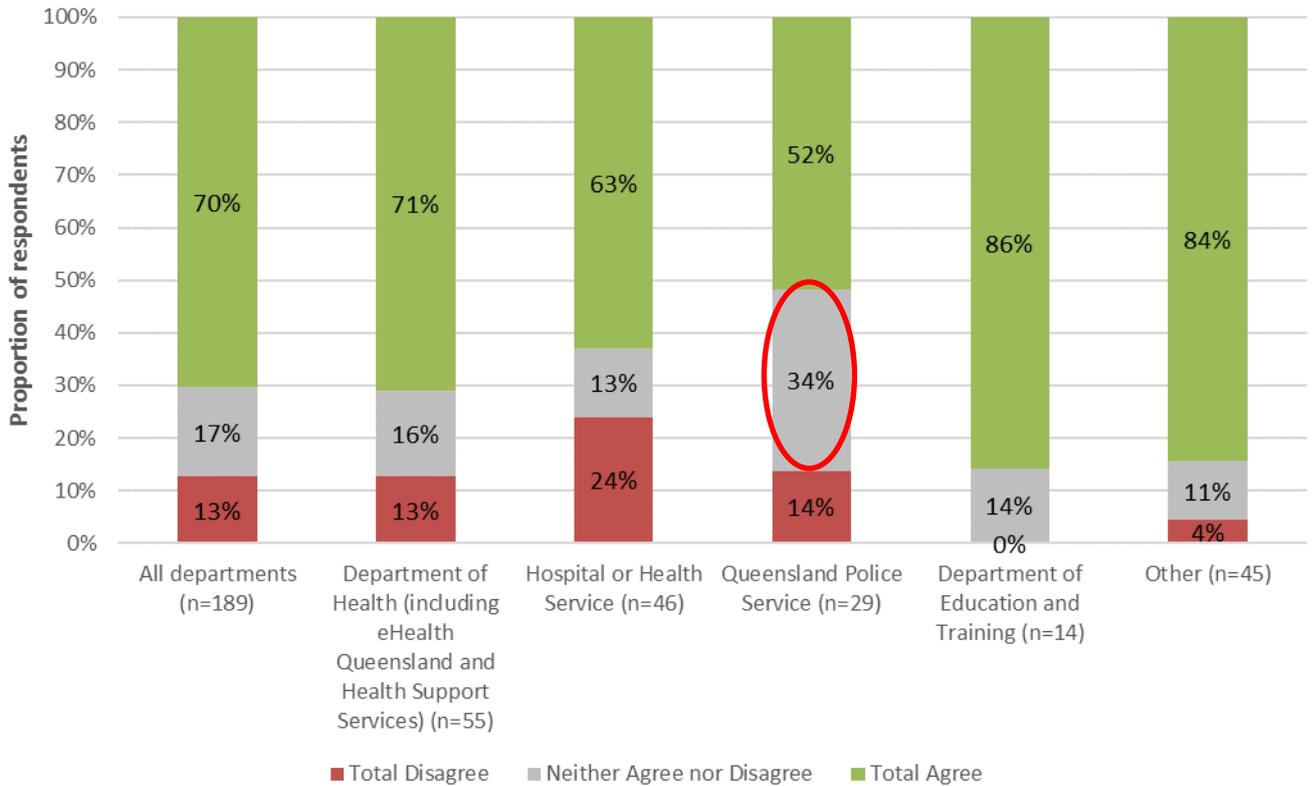
Irrespective of personal role, the majority (ranging from 71% to 87% by role) of 2016 respondents reported viewing the QMHC as an important driver of reform of the mental health, drug and alcohol system in QLD (Figure 15). Notably, approximately 80% of consumers, families and carers viewed the QMHC as an important driver of reform.

Figure 15: "I view the QMHC as an important driver of reform of the mental health, drug and alcohol system in QLD." – by personal role



Queensland Police were the government employees for which the lowest proportion of respondents (52%) viewed the QMHC as an important driver of reform. However, this group also had the largest proportion of respondents who reported being unable to comment on the question (34%). A smaller proportion of HHS employees saw the QMHC as an important driver of reform than that of Department of Health employees (63% vs 71%). This finding is consistent with the findings of other survey questions that suggests adequate engagement at the department level but a need for improved engagement at the HHS and frontline service provision levels.

Figure 16: “I view the QMHC as an important driver of reform of the mental health, drug and alcohol system in QLD.” – by department



The majority of respondents from all sectors (ranging from 72 to 100%, by sector) (Figure 17) and priority population groups (ranging from 70% to 88%, by group) (Figure 18) also viewed the QMHC as an important driver of reform.

Figure 17: “I view the QMHC as an important driver of reform of the mental health, drug and alcohol system in QLD.” – by sector

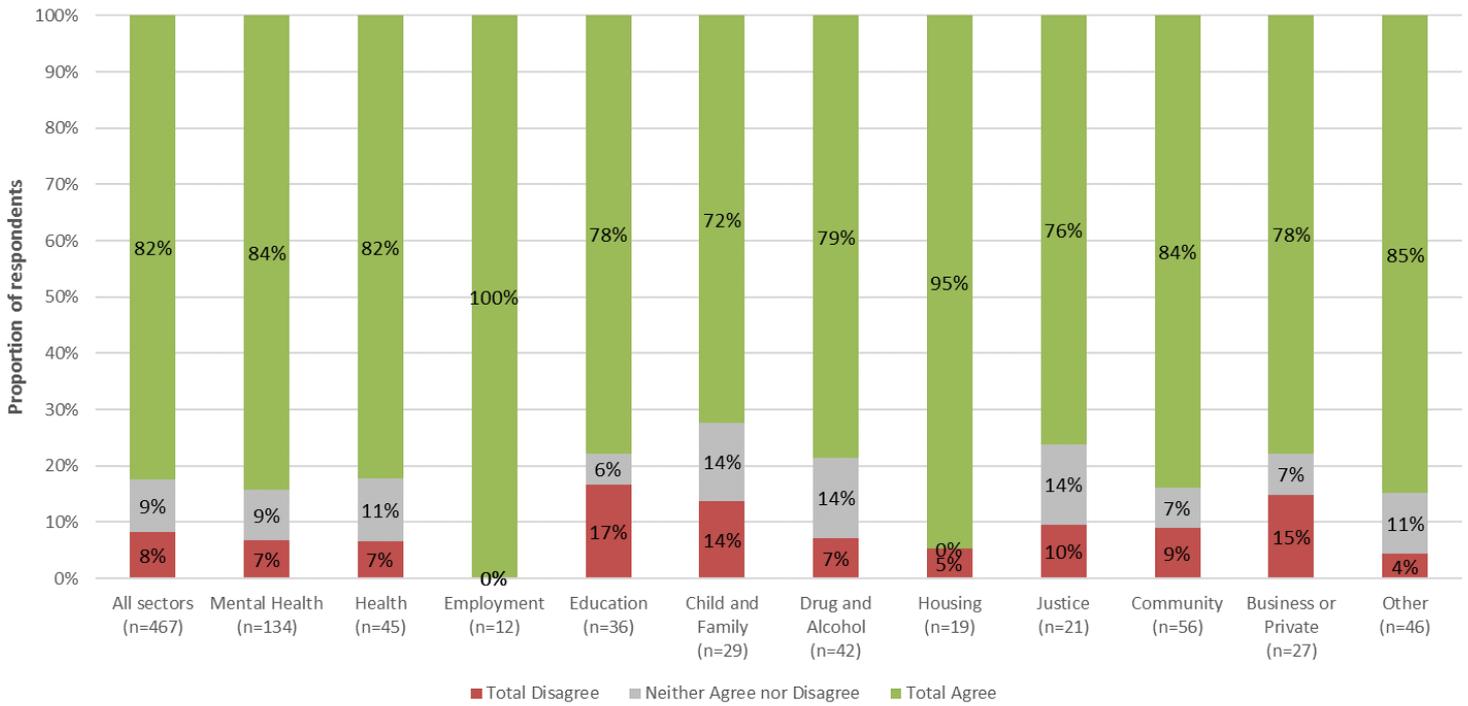
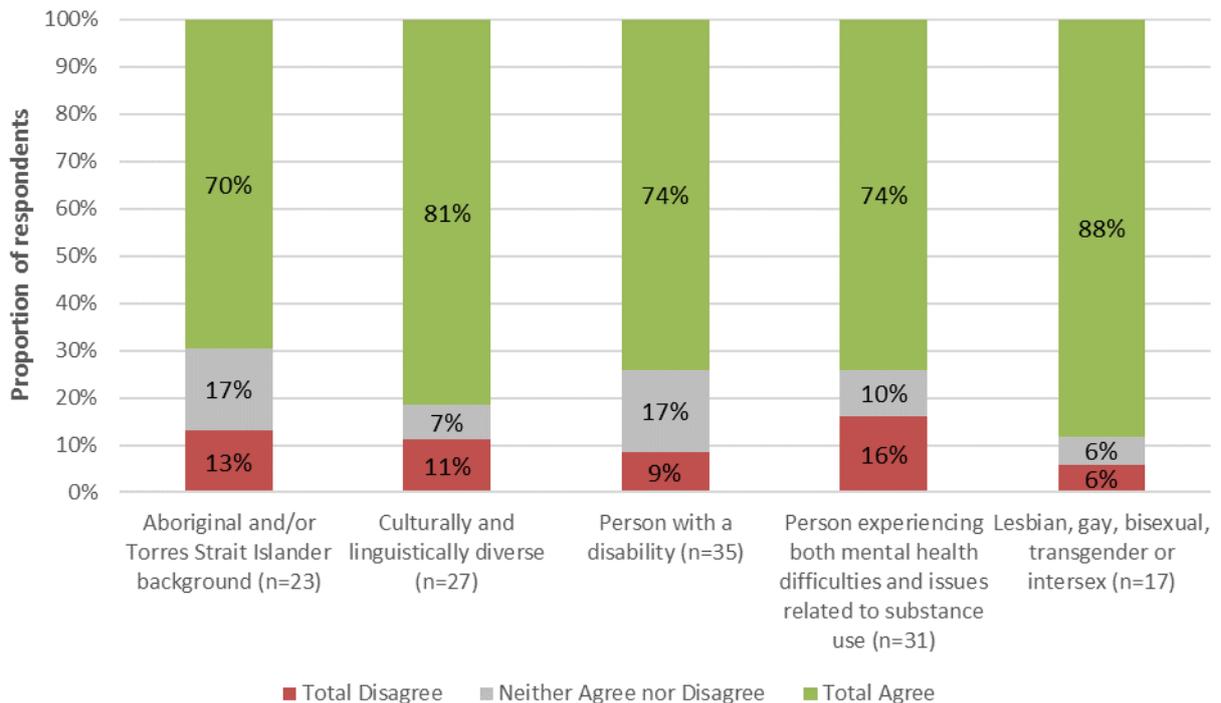


Figure 18: “I view the QMHC as an important driver of reform of the mental health, drug and alcohol system in QLD.” – by priority population



3.3 QMHC Key Results Areas

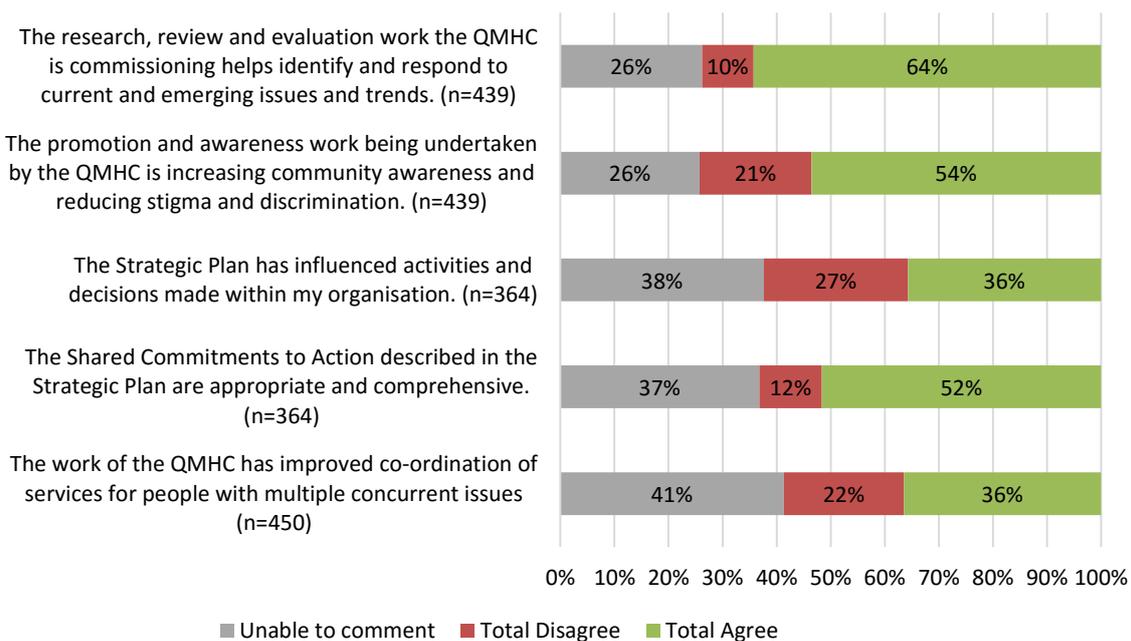
This section provides an overview of the key survey questions regarding each of the QMHC’s key result areas (KRAs) of:

- Research, Review and Reporting
- Promotion and Awareness
- Strategic Planning
- Systemic Governance

Figure 19 presents the 2016 survey results for each of the core questions related to the QMHC’s KRAs. Almost two-thirds (64%) of respondents agreed that the QMHC’s research, review and evaluation work is helping to identify and respond to current and emerging issues and trends. Just over half (54%) agreed that the promotion and awareness work being undertaken by the QMHC is increasing community awareness and reducing stigma and discrimination. With respect to the Strategic Plan, just over half of respondents agreed that the Shared Commitments to Action were appropriate and comprehensive. However, only 36% agreed that the Strategic Plan had influenced activities and decisions made within their organisation, while an almost equivalent proportion (38%) felt unable to comment.

Respondents were least able to comment on whether the work of the QMHC had improved the co-ordination of services for people with multiple concurrent issues (41% unable to comment). However, of those that did answer, the majority agreed that they had improved co-ordination (36% Agreed vs 22% Disagreed).

Figure 19: Overview of QMHC Key Result Areas



A section on each of the QMHC’s KRAs is provided below, with raw survey results broken down by:

- Trend in survey results over time (where possible)
- Personal role of respondent
- Department of respondent (where applicable)
- Organisational role of respondent
- Sector of respondent
- Priority populations
- Rurality of respondents (where possible).

3.3.1 Research, Review and Reporting

Figure 20 shows that almost two-thirds of respondents across all years agreed that the research, review and evaluation work that the QMHC is commissioning helps to identify and respond to current and emerging issues and trends.

Figure 20: “The research, review and evaluation work the QMHC is commissioning helps identify and respond to current and emerging issues and trends.”– over time

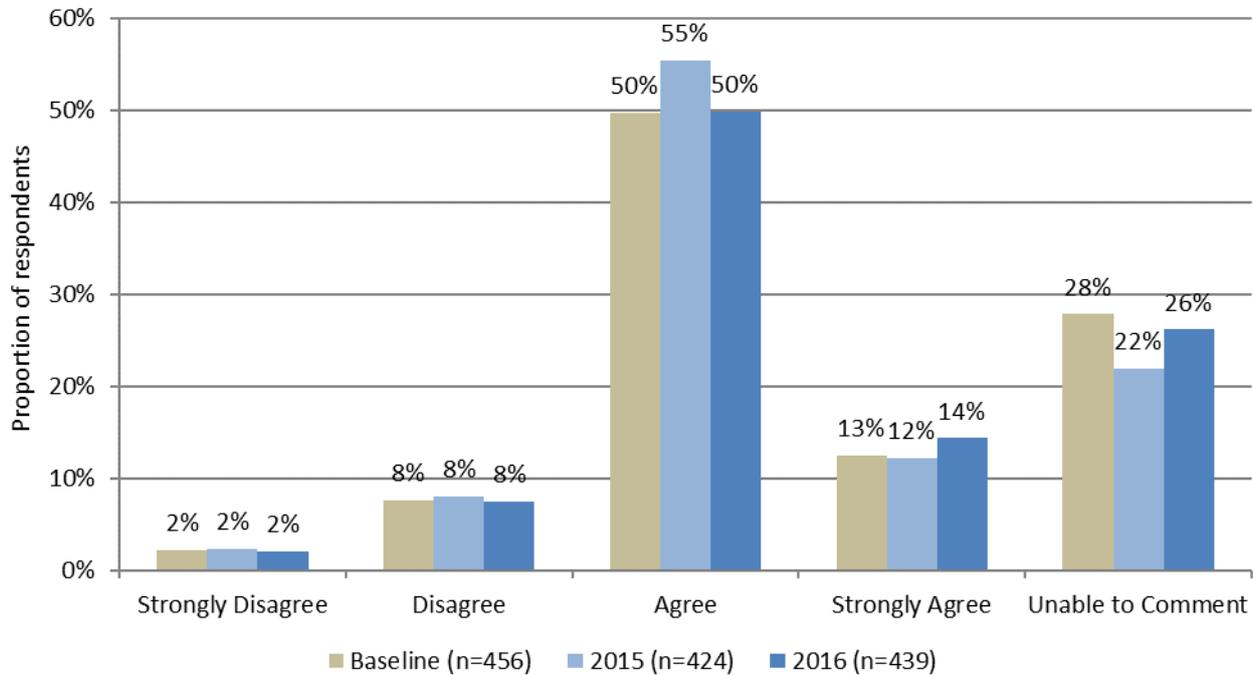


Figure 21: “The research, review and evaluation work the QMHC is commissioning helps identify and respond to current and emerging issues and trends.”– by personal role

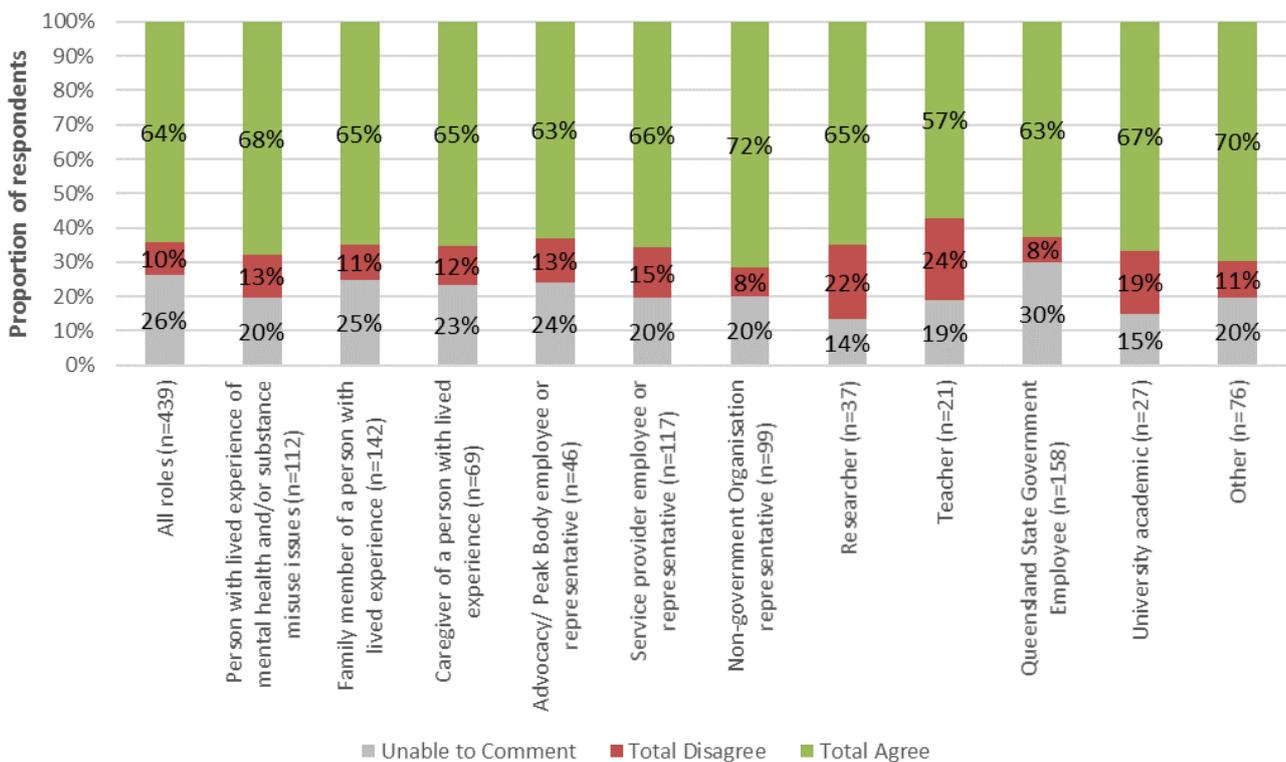


Figure 22: “The research, review and evaluation work the QMHC is commissioning helps identify and respond to current and emerging issues and trends.”– by department

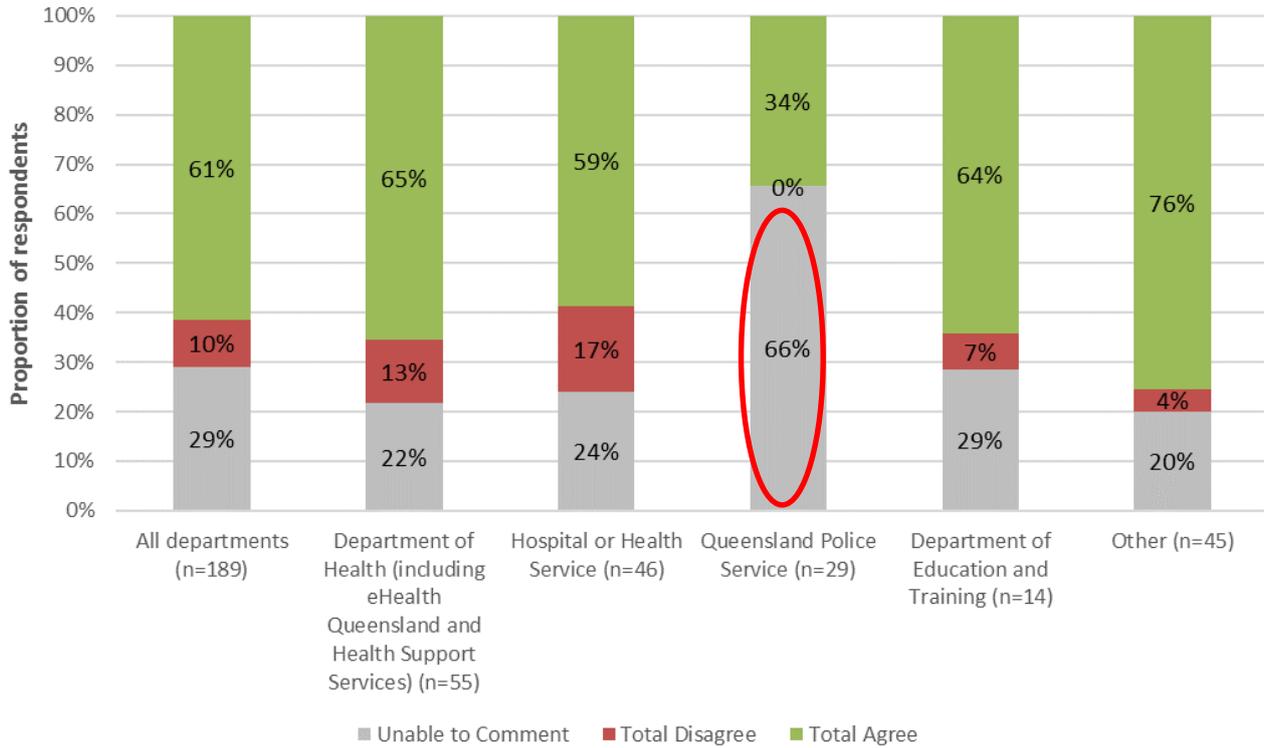


Figure 23: “The research, review and evaluation work the QMHC is commissioning helps identify and respond to current and emerging issues and trends.”– by organisational role

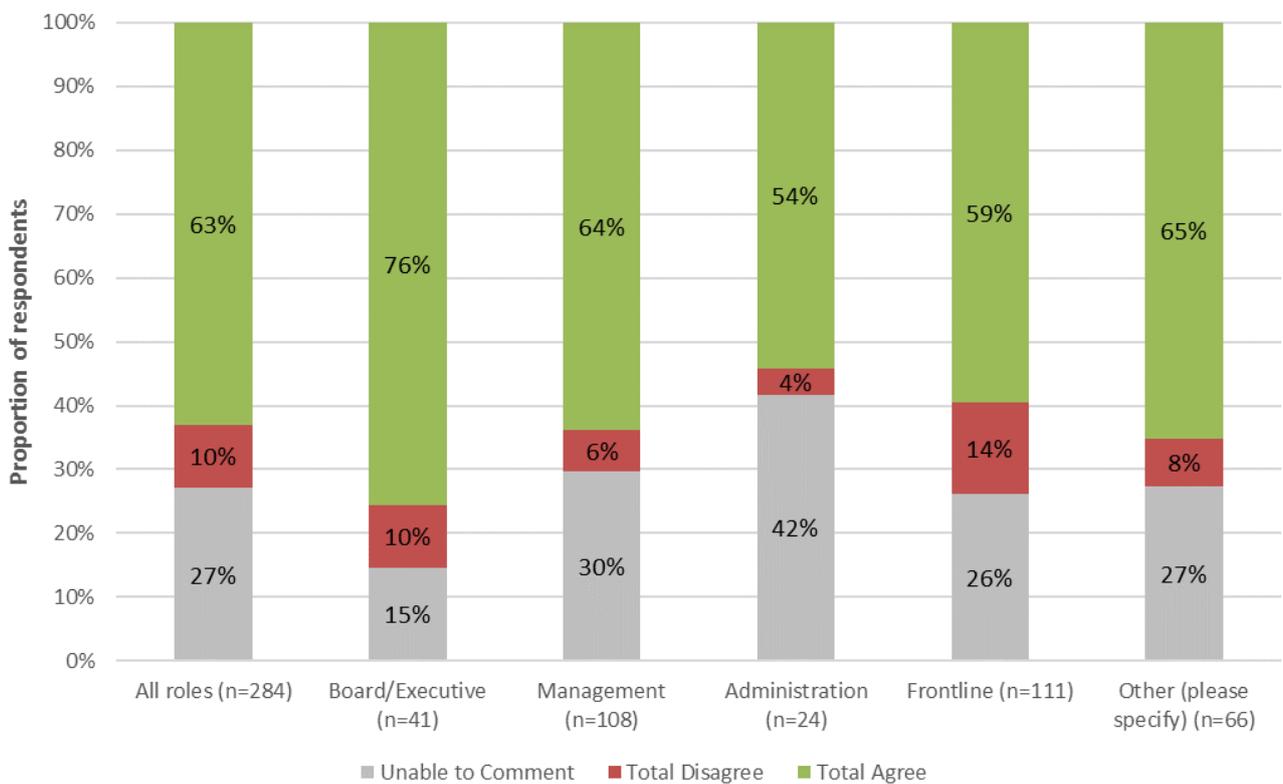


Figure 24: “The research, review and evaluation work the QMHC is commissioning helps identify and respond to current and emerging issues and trends.”– by sector

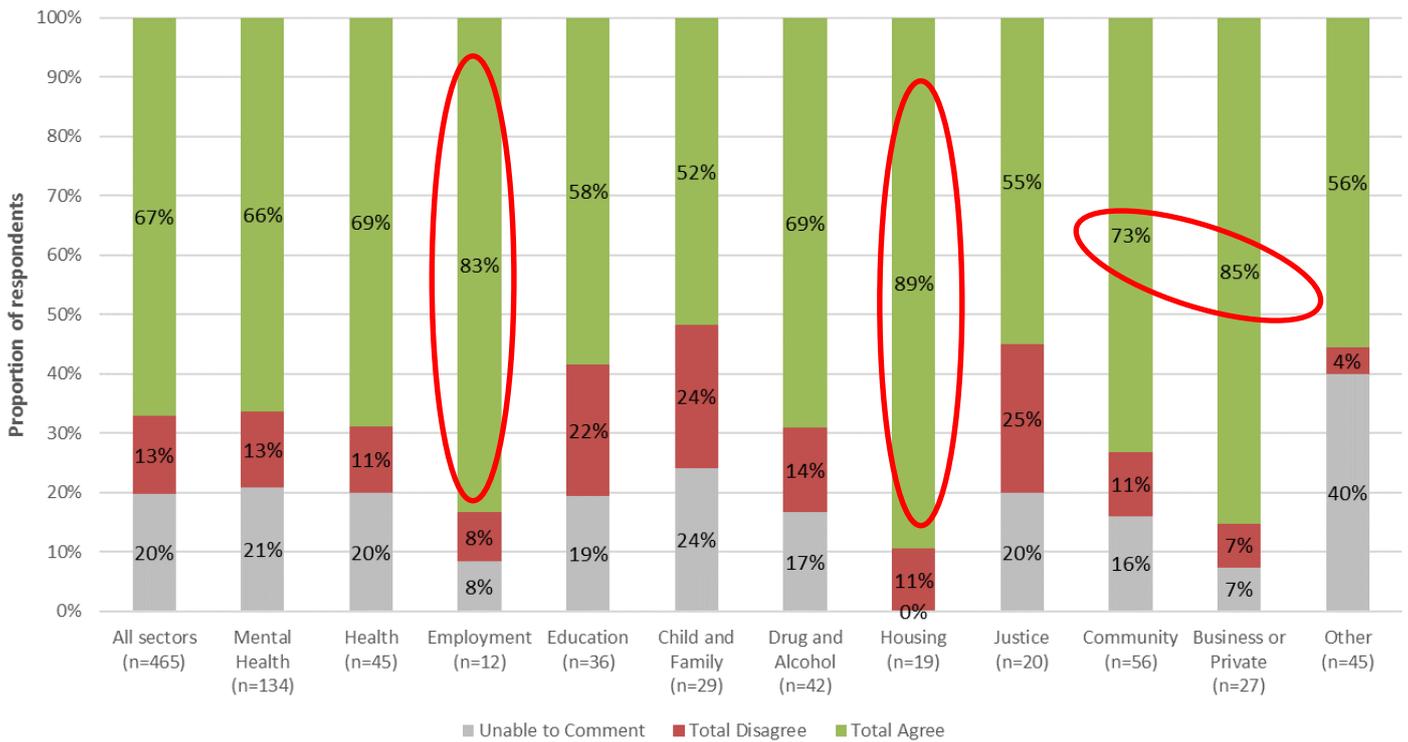


Figure 25: “The research, review and evaluation work the QMHC is commissioning helps identify and respond to current and emerging issues and trends.”– by priority population

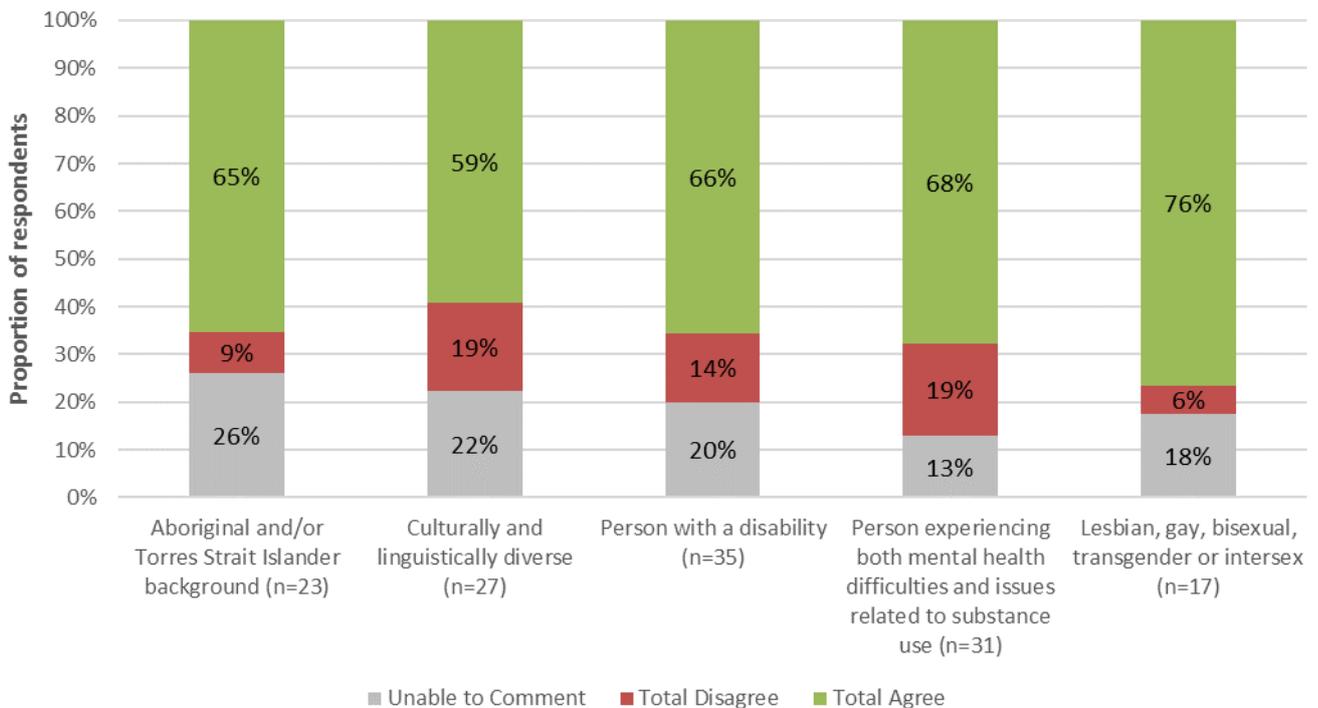


Figure 26: “The research, review and evaluation work the QMHC is commissioning helps identify and respond to current and emerging issues and trends.”– by rurality



3.3.2 Promotion and awareness

Over the last three years, the proportion of respondents agreeing that the promotion and awareness work undertaken by the QMHC is increasing community awareness and reducing stigma and discrimination has typically increased, while the proportion disagreeing has decreased (from 29% in 2014 to 21% in 2016). Close to a quarter of respondents in each year reported being unable to comment.

Figure 27: “The promotion and awareness work being undertaken by the QMHC is increasing community awareness and reducing stigma and discrimination.”– over time

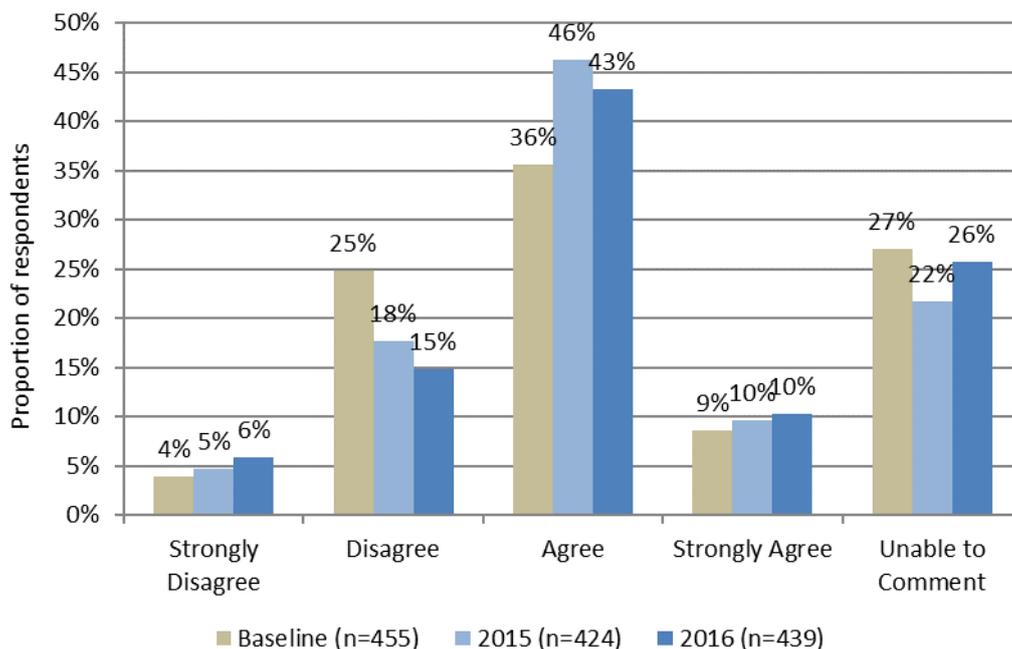


Figure 28: “The promotion and awareness work being undertaken by the QMHC is increasing community awareness and reducing stigma and discrimination.” – by personal role

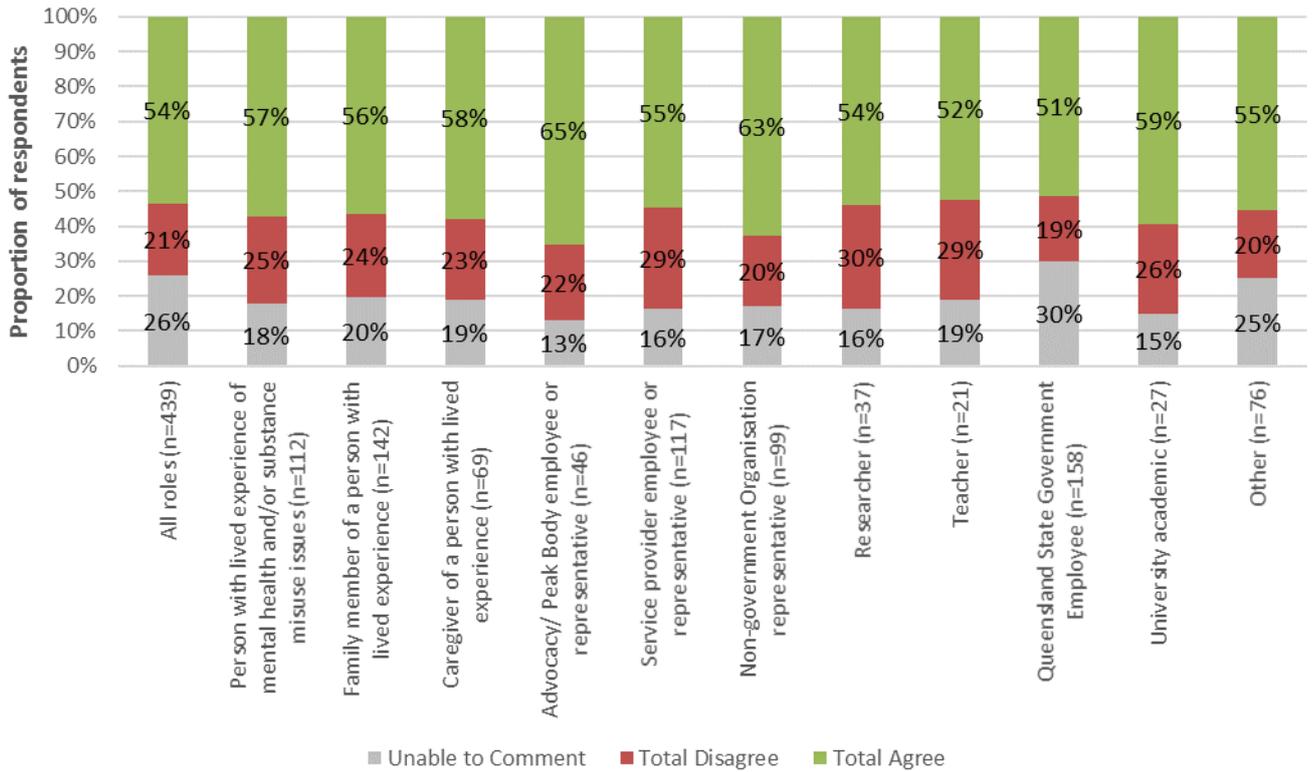


Figure 29: “The promotion and awareness work being undertaken by the QMHC is increasing community awareness and reducing stigma and discrimination.” – by department

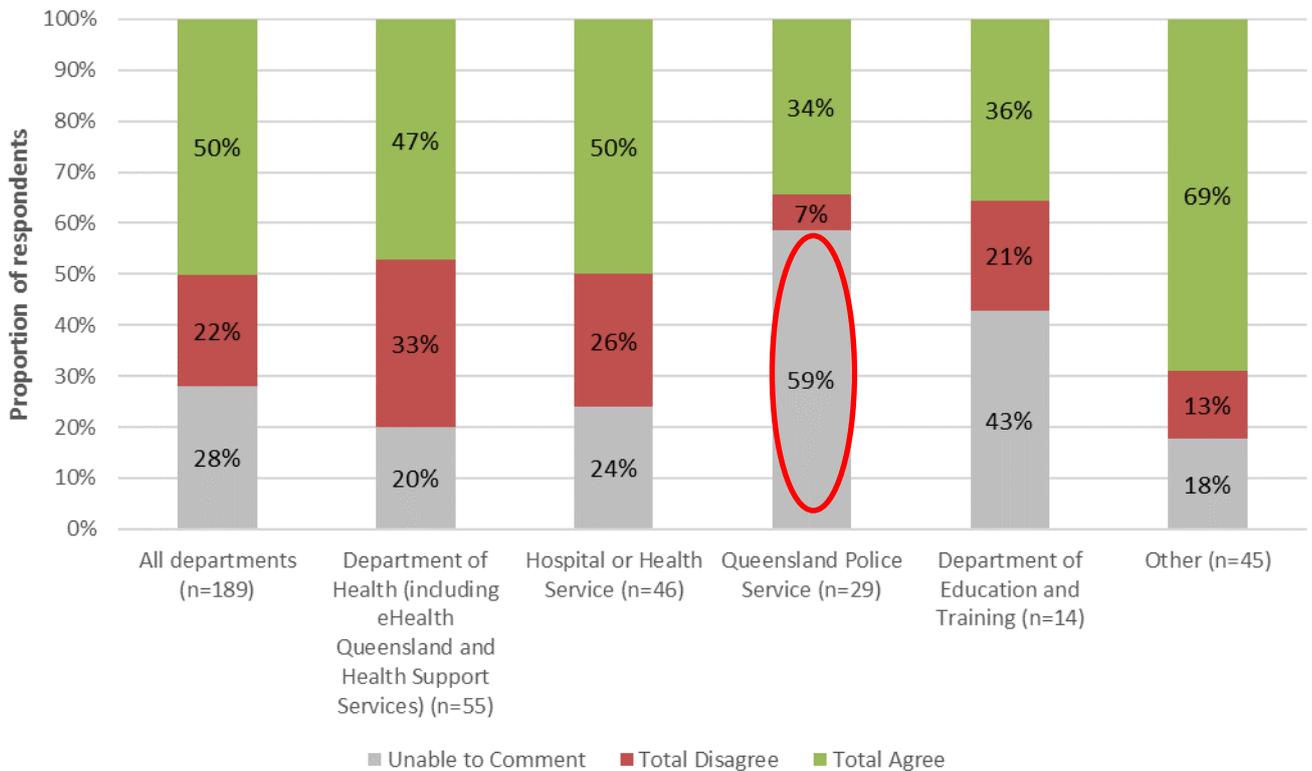


Figure 30: “The promotion and awareness work being undertaken by the QMHC is increasing community awareness and reducing stigma and discrimination.” – by organisational role

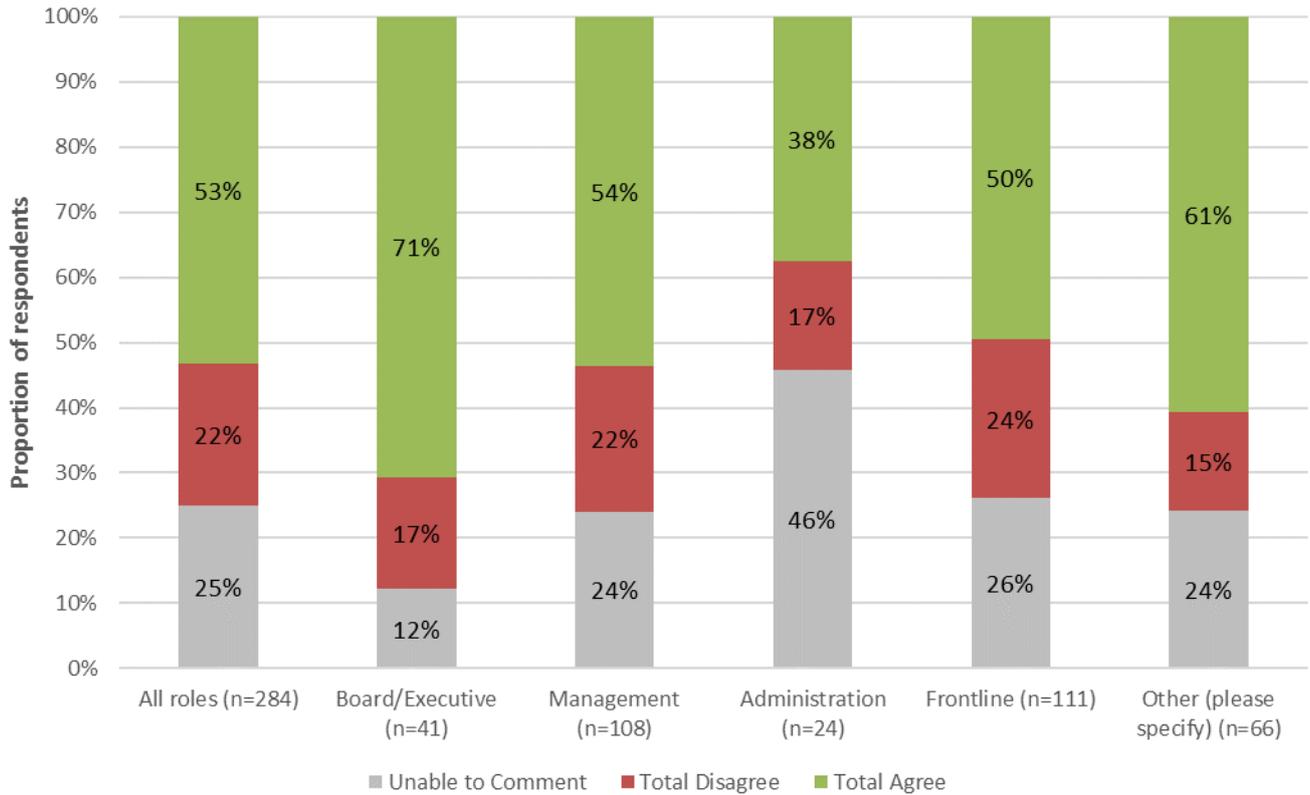


Figure 31: “The promotion and awareness work being undertaken by the QMHC is increasing community awareness and reducing stigma and discrimination.” – by sector

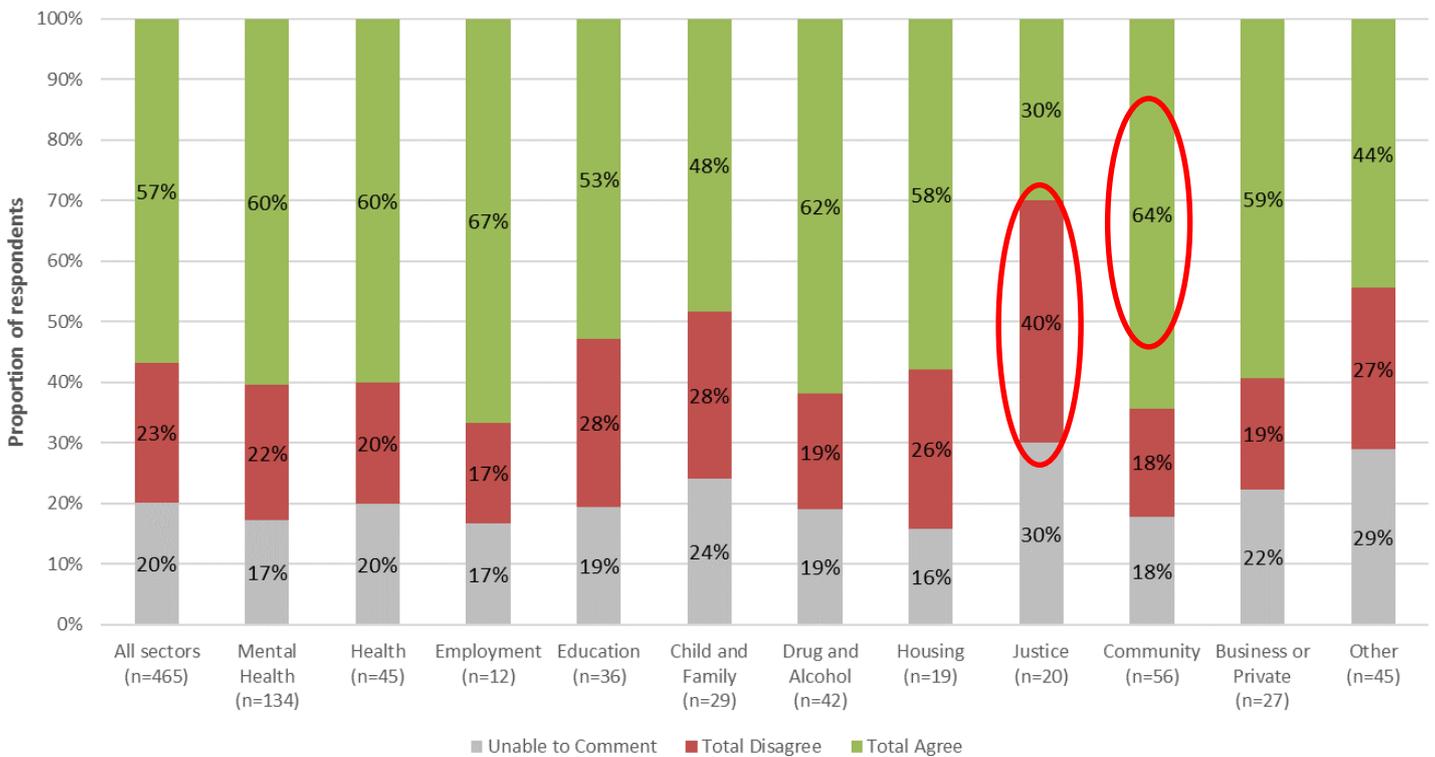


Figure 32: “The promotion and awareness work being undertaken by the QMHC is increasing community awareness and reducing stigma and discrimination.”– by priority population

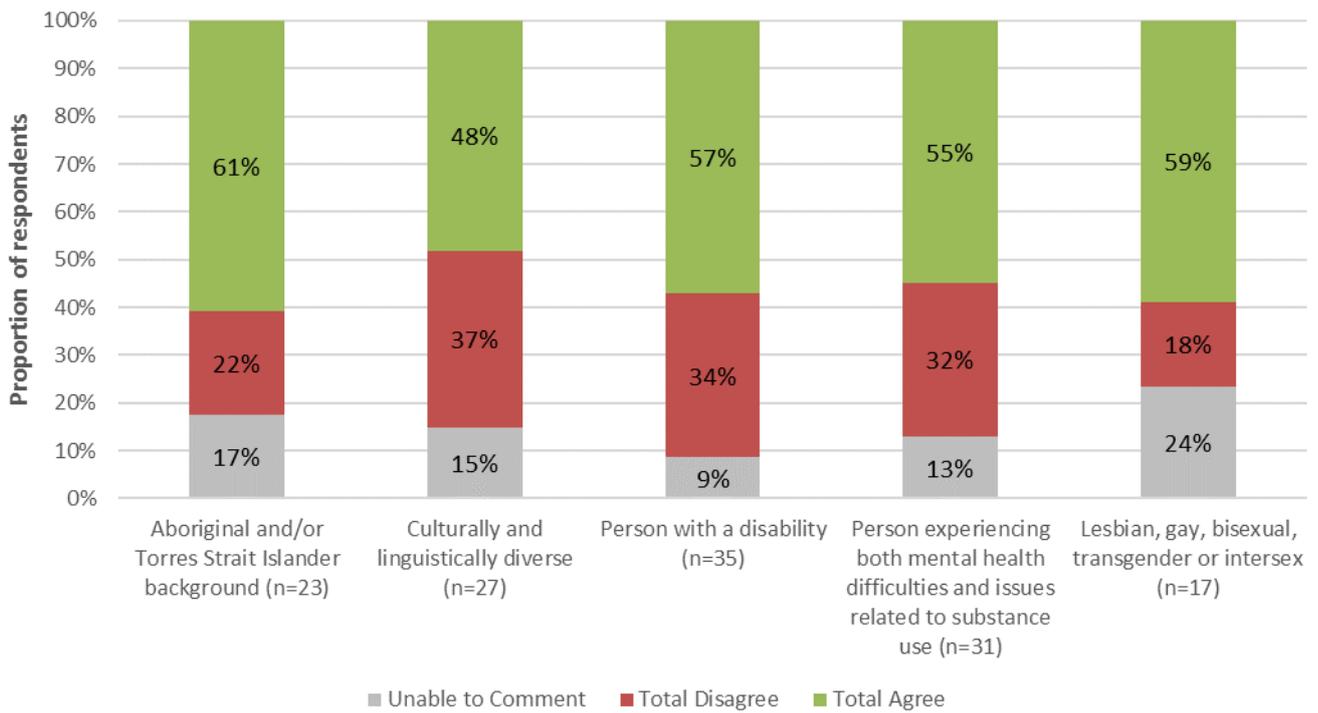


Figure 33: “The promotion and awareness work being undertaken by the QMHC is increasing community awareness and reducing stigma and discrimination.”– by rurality



3.3.3 Systemic governance

A new question was added to the 2016 survey to assess the QMHC’s effectiveness with respect to improving systemic governance and the co-ordination of services for people with multiple concurrent issues.

Figure 34 shows that a substantial proportion of respondents (ranging from 28% to 45%, depending on personal role) indicated not being able to answer the question and an approximately equivalent proportion (32% to 48%) agreed that the work of the QMHC has improved co-ordination of service for people with multiple concurrent issues.

Figure 34: “The work of the QMHC has improved co-ordination of services for people with multiple concurrent issues (e.g. mental health, substance misuse, disability, chronic disease, homelessness, and/or involvement with the criminal justice system).” – by personal role

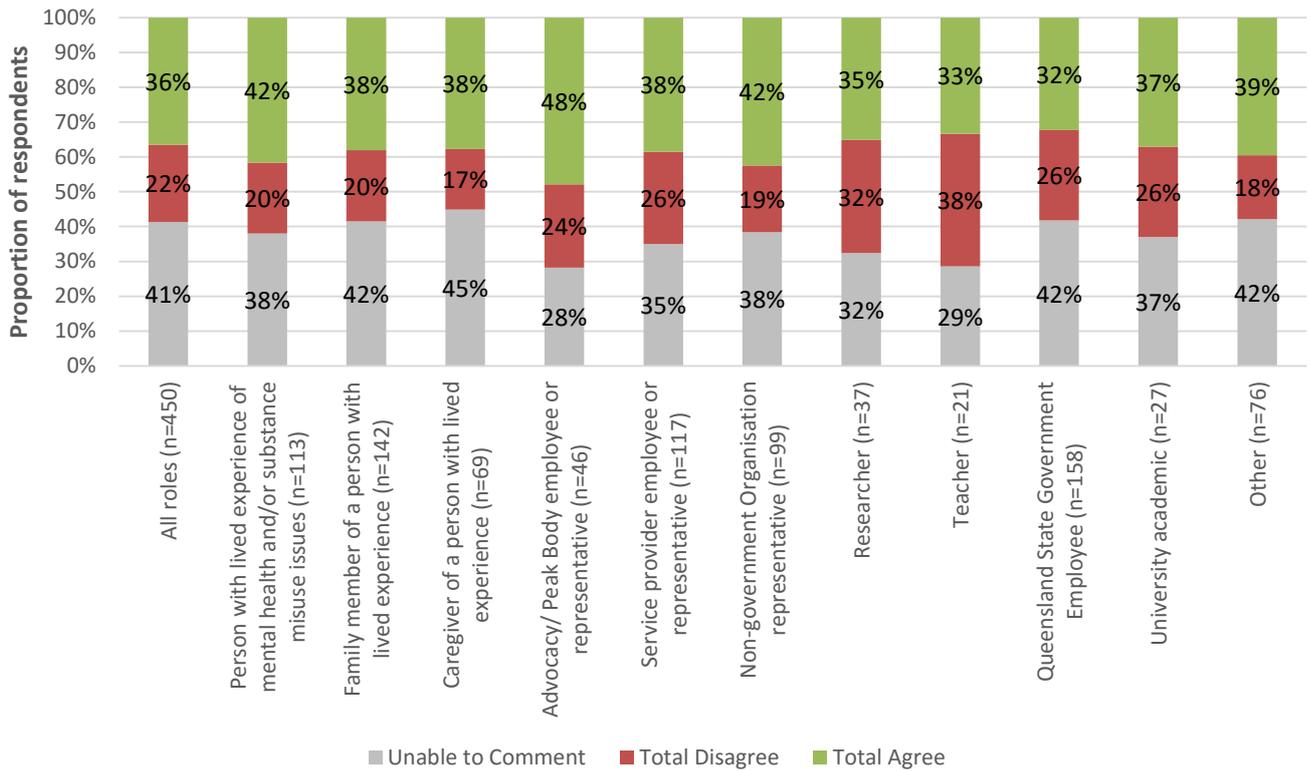


Figure 35: “The work of the QMHC has improved co-ordination of services for people with multiple concurrent issues (e.g. mental health, substance misuse, disability, chronic disease, homelessness, and/or involvement with the criminal justice system).” – by department

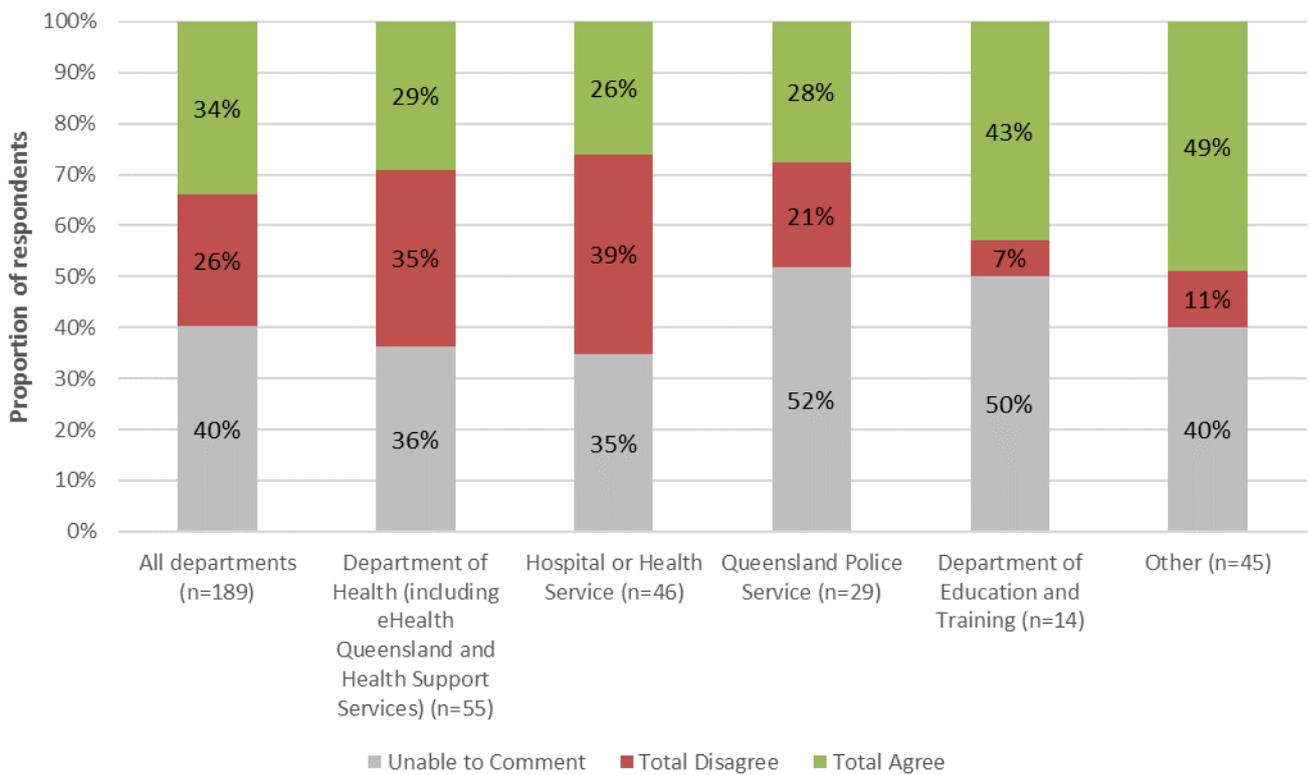


Figure 36: “The work of the QMHC has improved co-ordination of services for people with multiple concurrent issues (e.g. mental health, substance misuse, disability, chronic disease, homelessness, and/or involvement with the criminal justice system).” – by sector

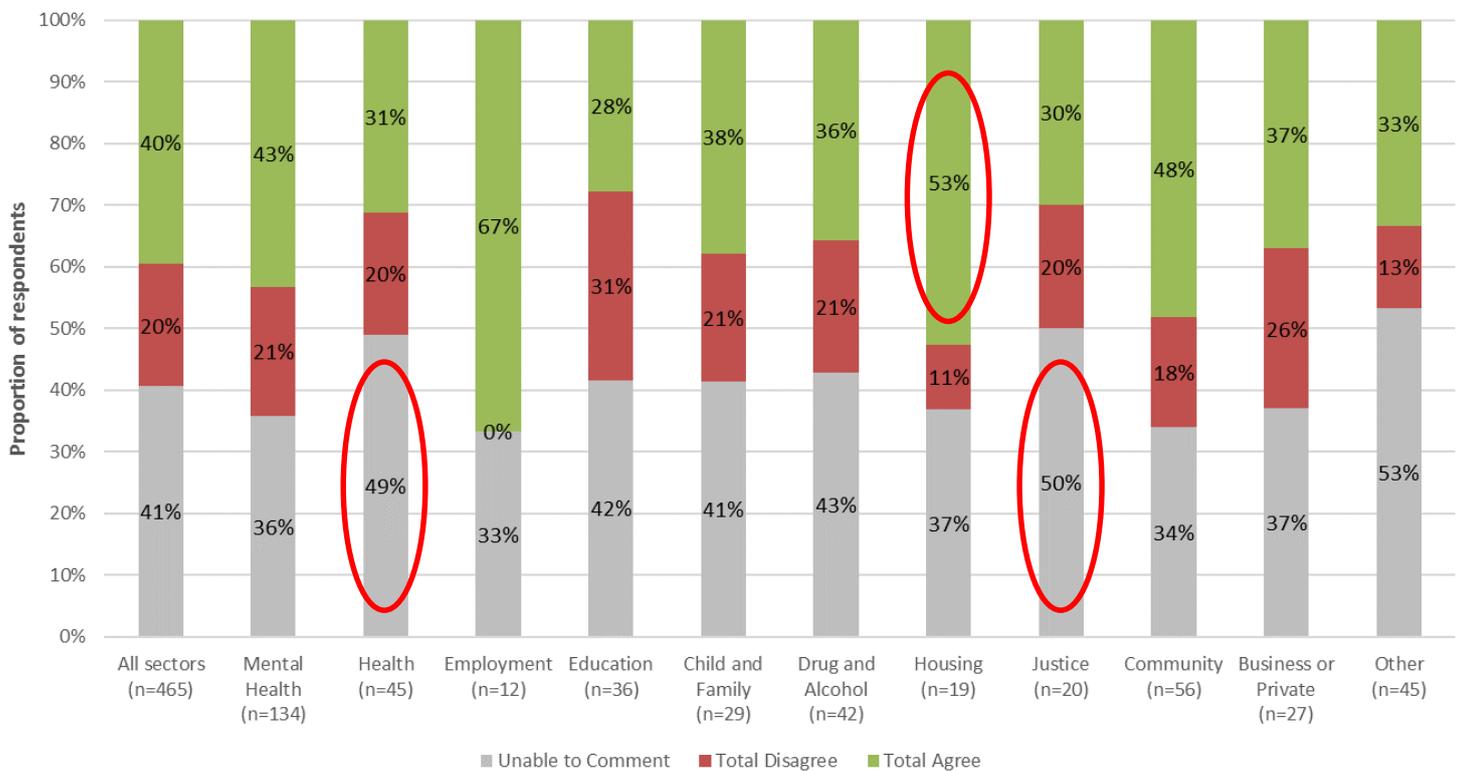


Figure 37: “The work of the QMHC has improved co-ordination of services for people with multiple concurrent issues (e.g. mental health, substance misuse, disability, chronic disease, homelessness, and/or involvement with the criminal justice system).” – by priority population

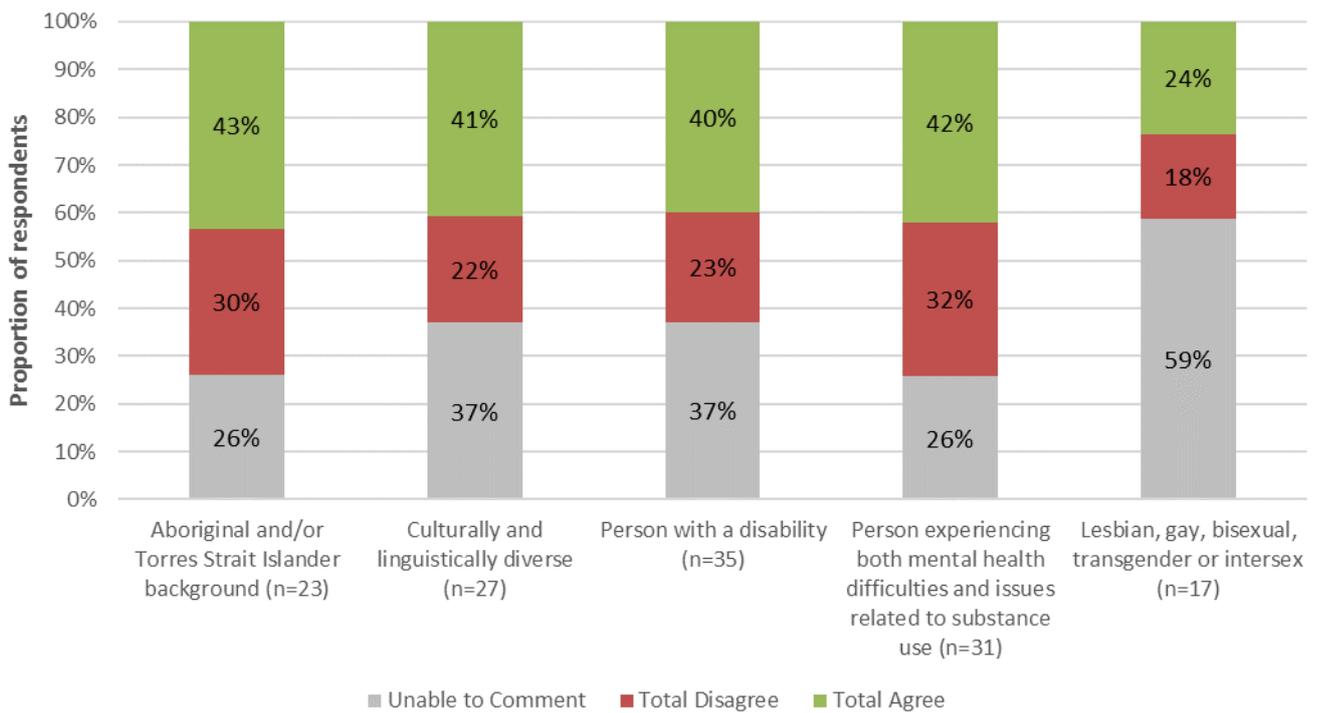
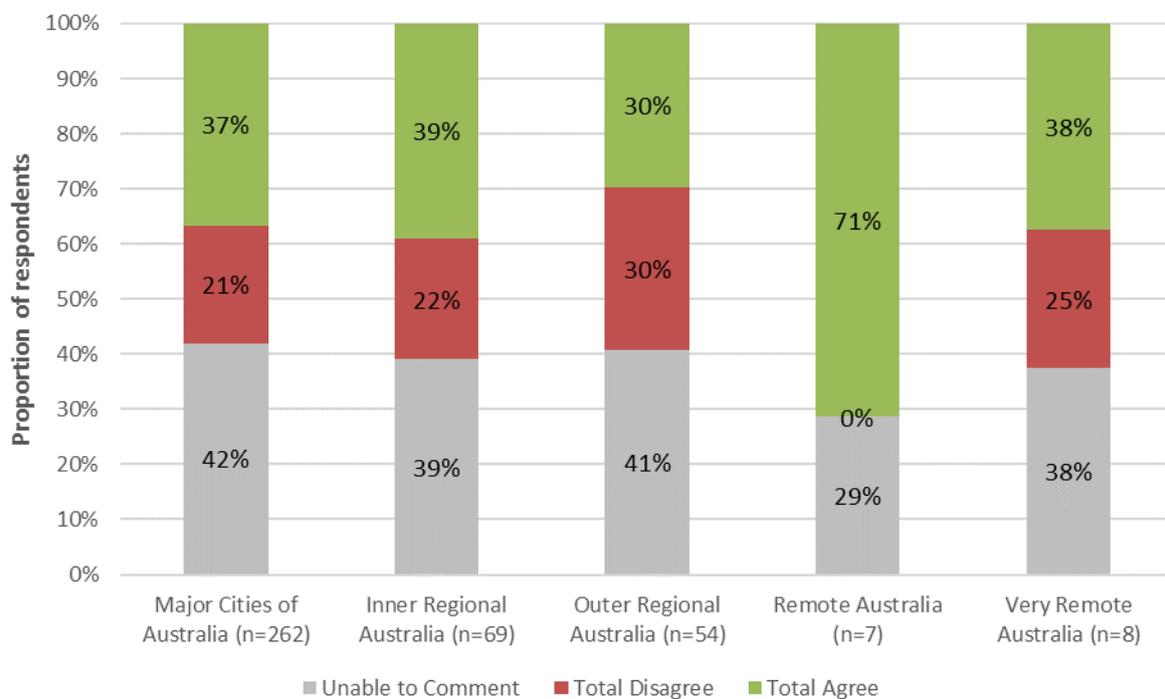


Figure 38: “The work of the QMHC has improved co-ordination of services for people with multiple concurrent issues (e.g. mental health, substance misuse, disability, chronic disease, homelessness, and/or involvement with the criminal justice system).” – by rurality



3.3.4 Strategic Plan

The majority of respondents across both 2015 and 2016 (~52%) agreed that the Shared Commitments to Action described in the Strategic Plan are appropriate and comprehensive (Figure 39). However, a large proportion (31% in 2015 and 37% in 2016) reported being unable to answer the question, suggesting that awareness of the Strategic Plan may still be low in amongst some stakeholder groups. Encouragingly, the proportion of respondents disagreeing with the statement decreased between 2015 and 2016 (12% compared to 9%).

Figure 39: “The Shared Commitments to Action described in the Strategic Plan are appropriate and comprehensive.” – over time

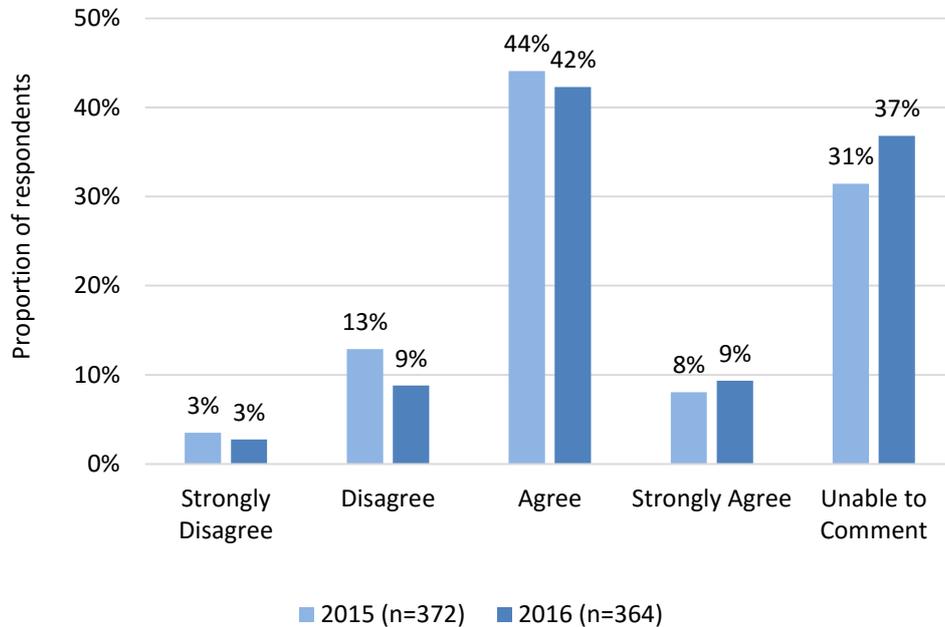


Figure 40: “The Shared Commitments to Action described in the Strategic Plan are appropriate and comprehensive.” – by personal role



Figure 41: “The Shared Commitments to Action described in the Strategic Plan are appropriate and comprehensive.”– by department

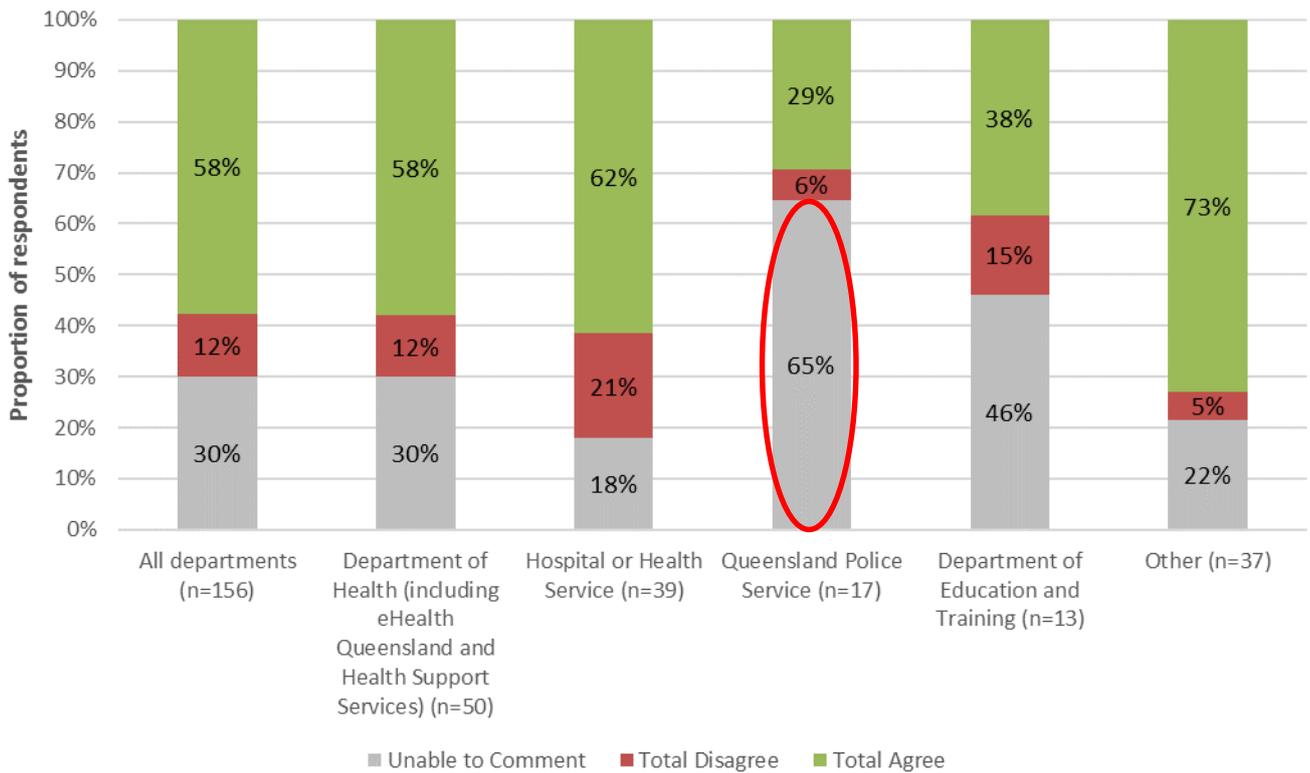


Figure 42: “The Shared Commitments to Action described in the Strategic Plan are appropriate and comprehensive.”– by sector

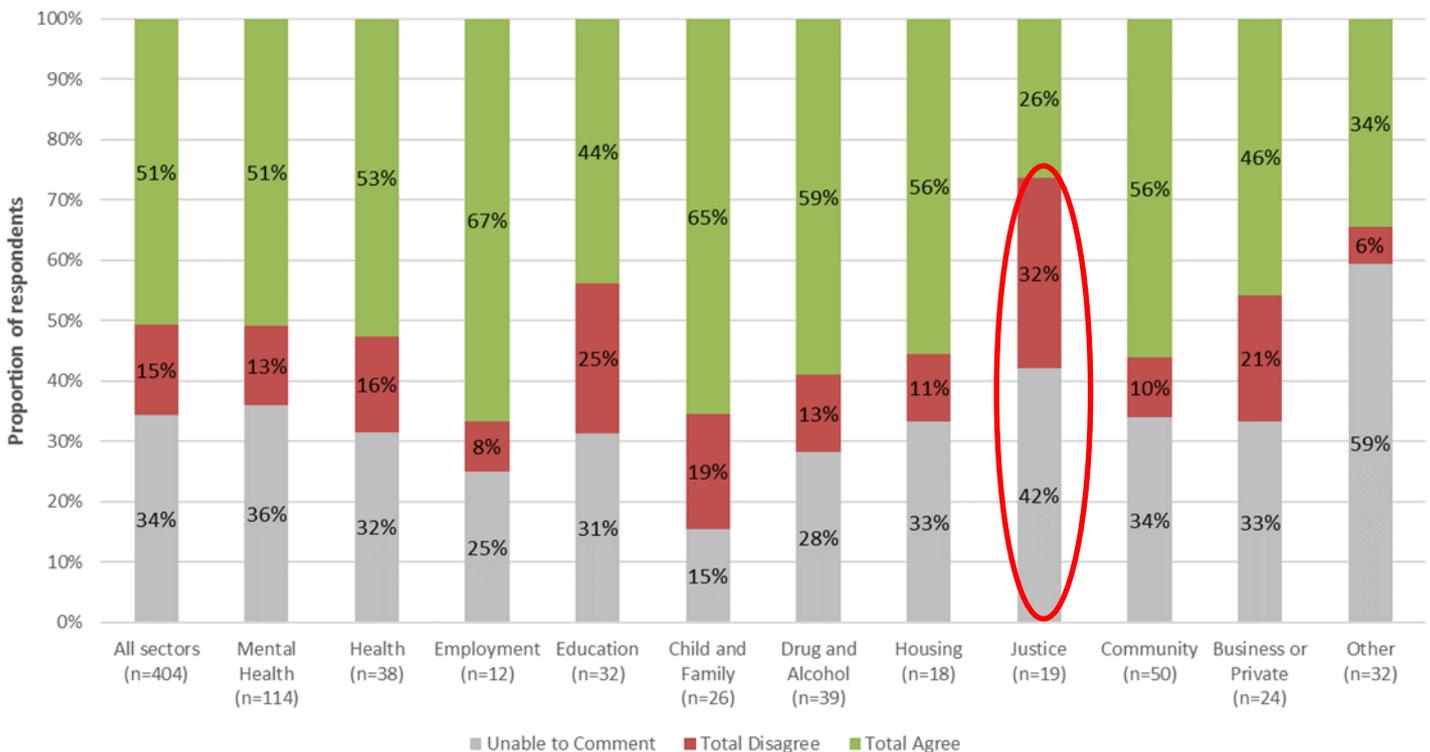


Figure 43: “The Shared Commitments to Action described in the Strategic Plan are appropriate and comprehensive.”– by priority population

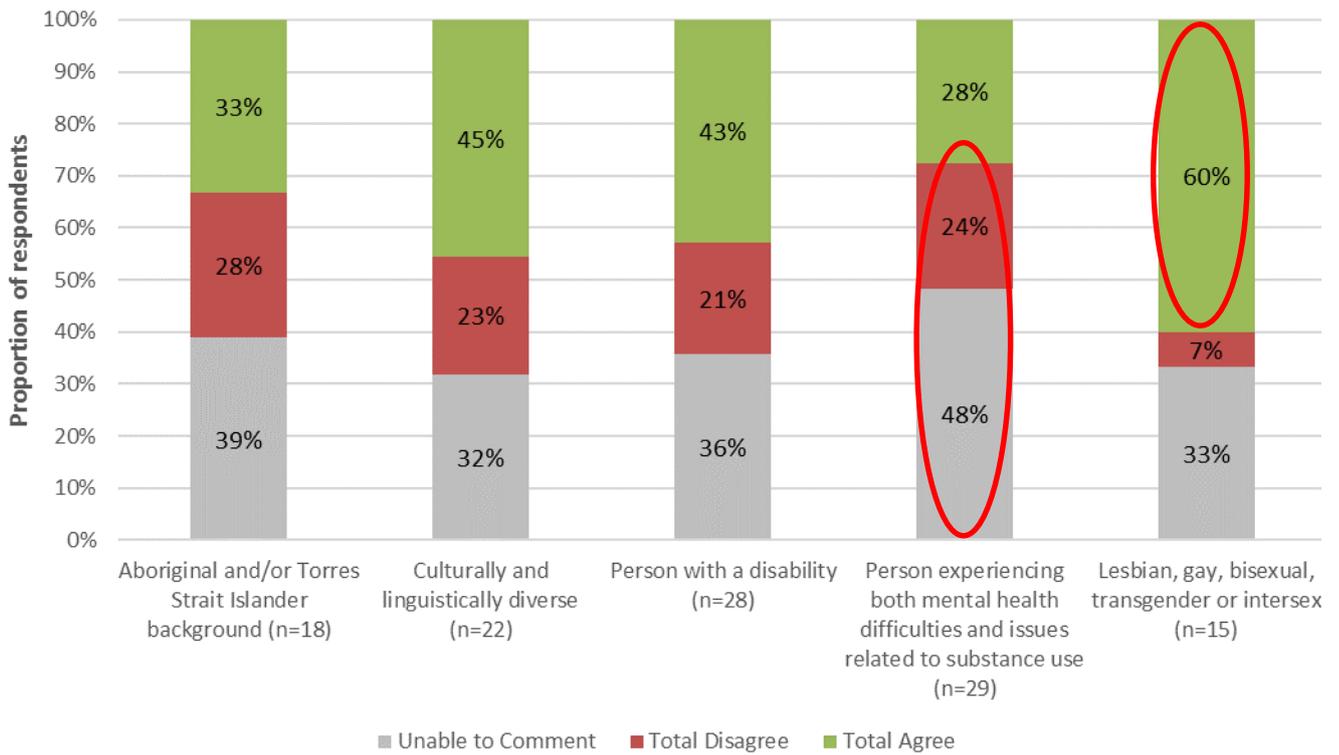


Figure 44: “The Shared Commitments to Action described in the Strategic Plan are appropriate and comprehensive.”– by rurality



Almost equivalent proportions of respondents agreed (~36%) as disagreed (27-36%) that the Strategic Plan had influenced activities and decisions made within their organisation (Figure 45). In addition, an almost equivalent proportion indicated being unable to comment (28% in 2015 and 38% in 2016). These results may be expected as the activities arising from the Strategic Plan to date are likely to have impacted different organisations and sectors to varying degrees, and in some cases not at all. It may also be difficult to attribute observed changes to any impact of the Strategic Plan. This may explain the large proportions of respondents reporting being unable to comment on whether the Strategic Plan has influenced activities and decision made with in their organisations.

Figure 45: “The Strategic Plan has influenced activities and decisions made within my organisation” – over time

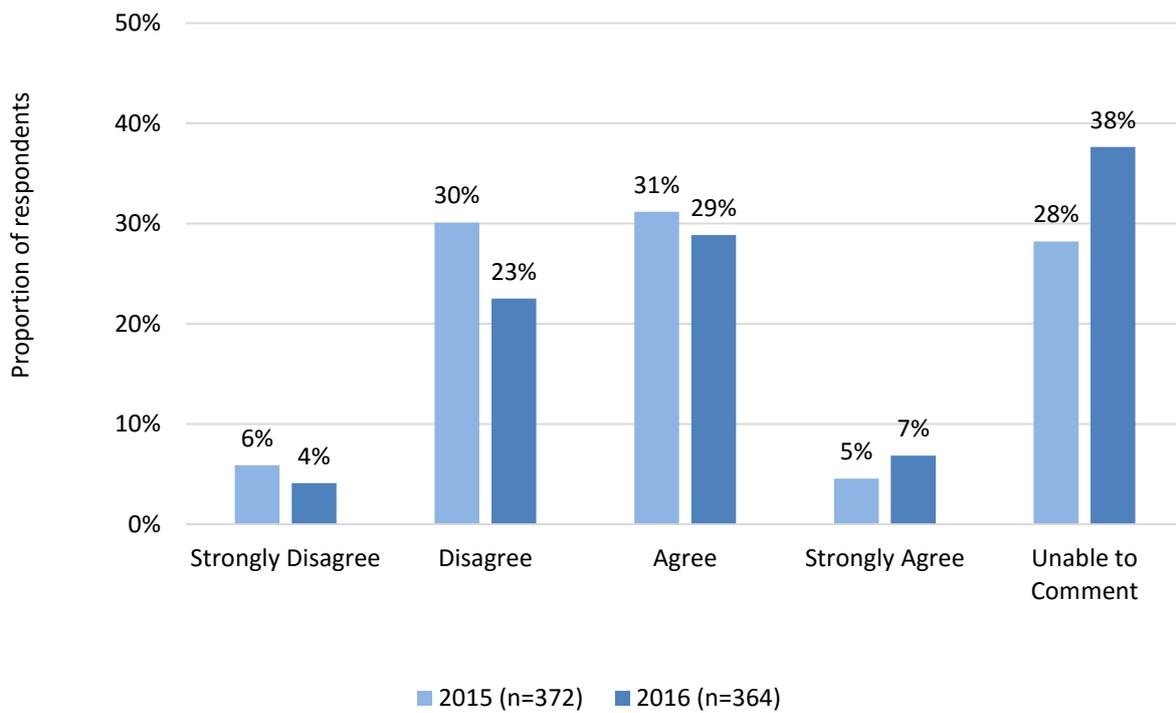


Figure 46: “The Strategic Plan has influenced activities and decisions made within my organisation.” – by personal role



Figure 47: “The Strategic Plan has influenced activities and decisions made within my organisation.”– by department

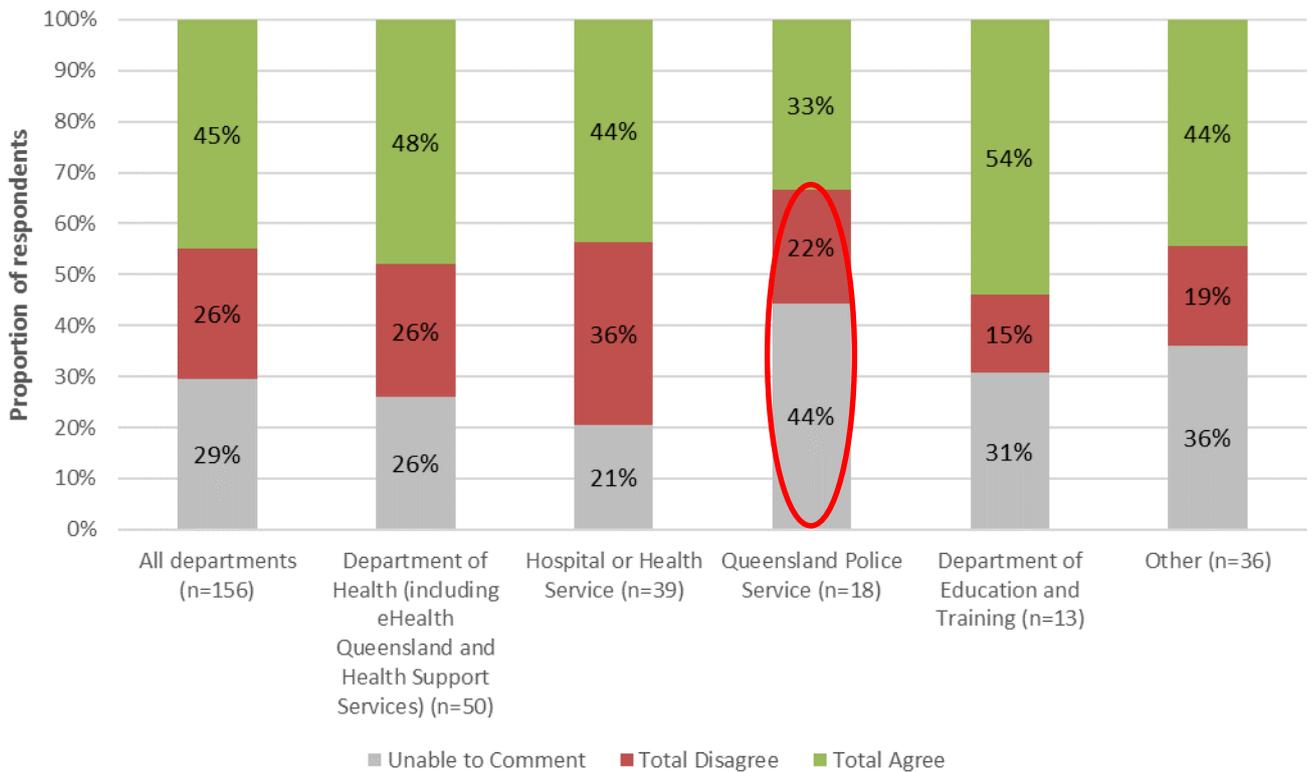


Figure 48: “The Strategic Plan has influenced activities and decisions made within my organisation.”– by sector

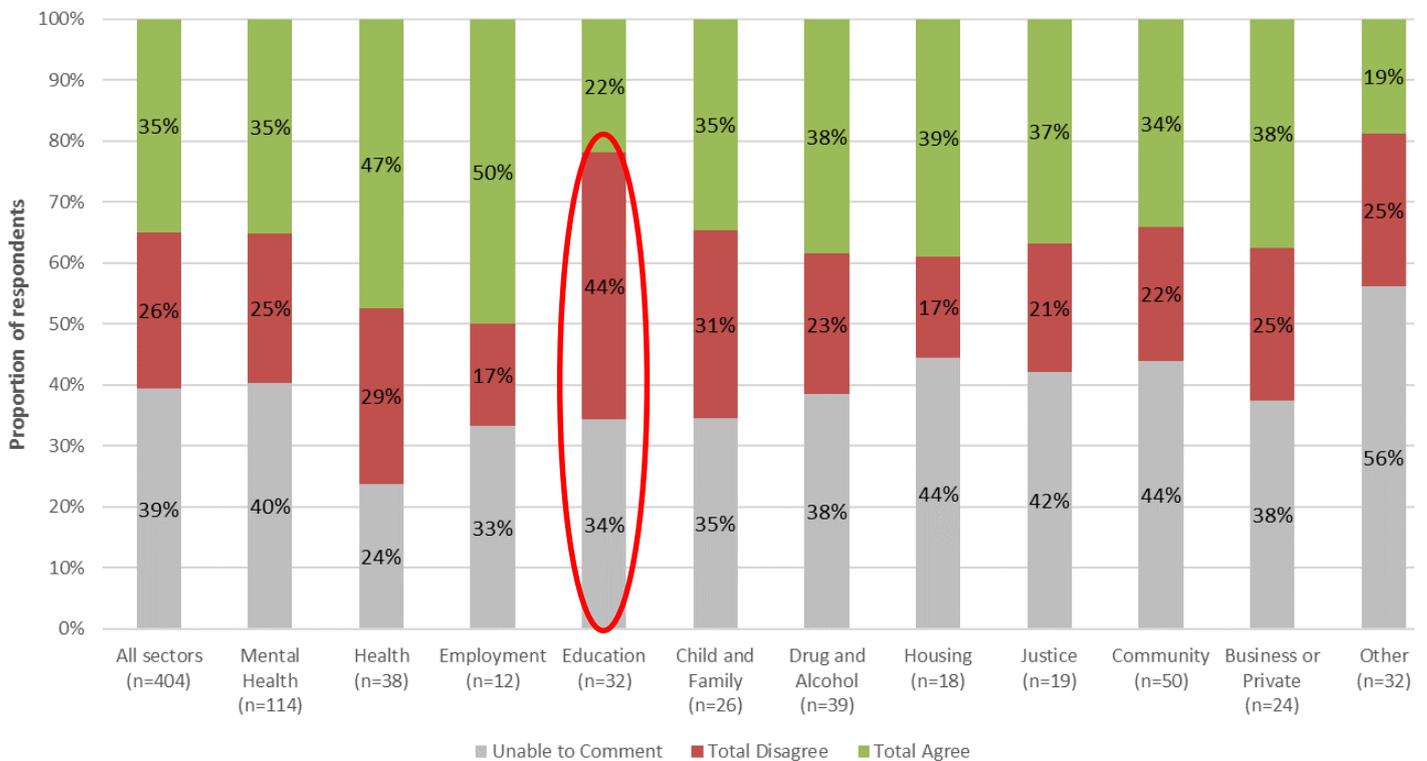
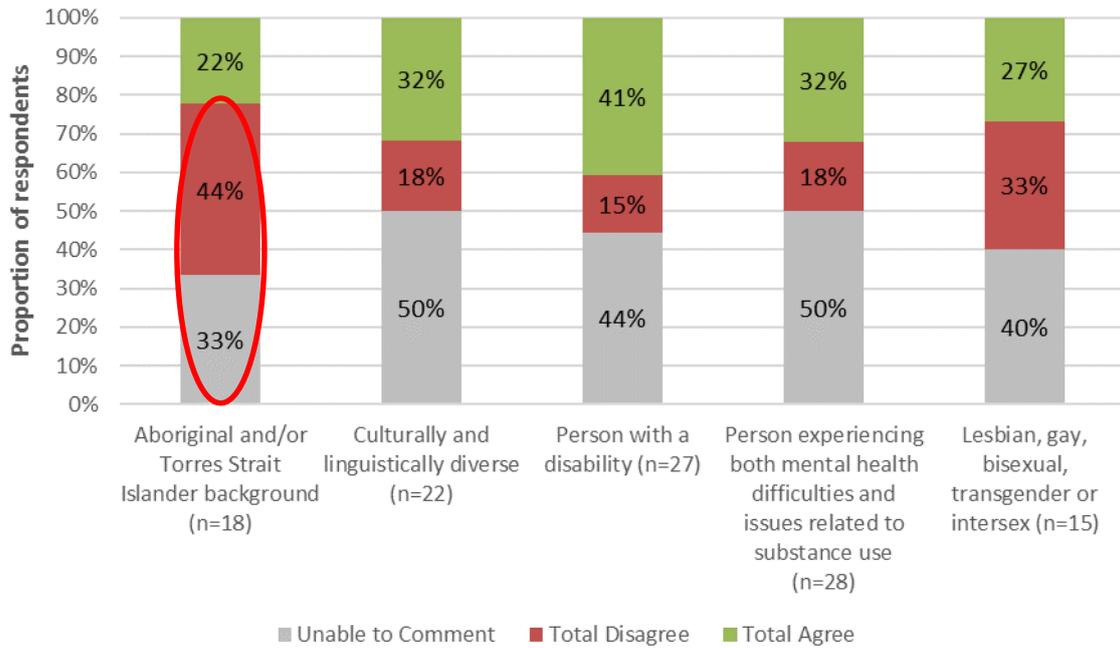


Figure 49: “The Strategic Plan has influenced activities and decisions made within my organisation.”– by priority population

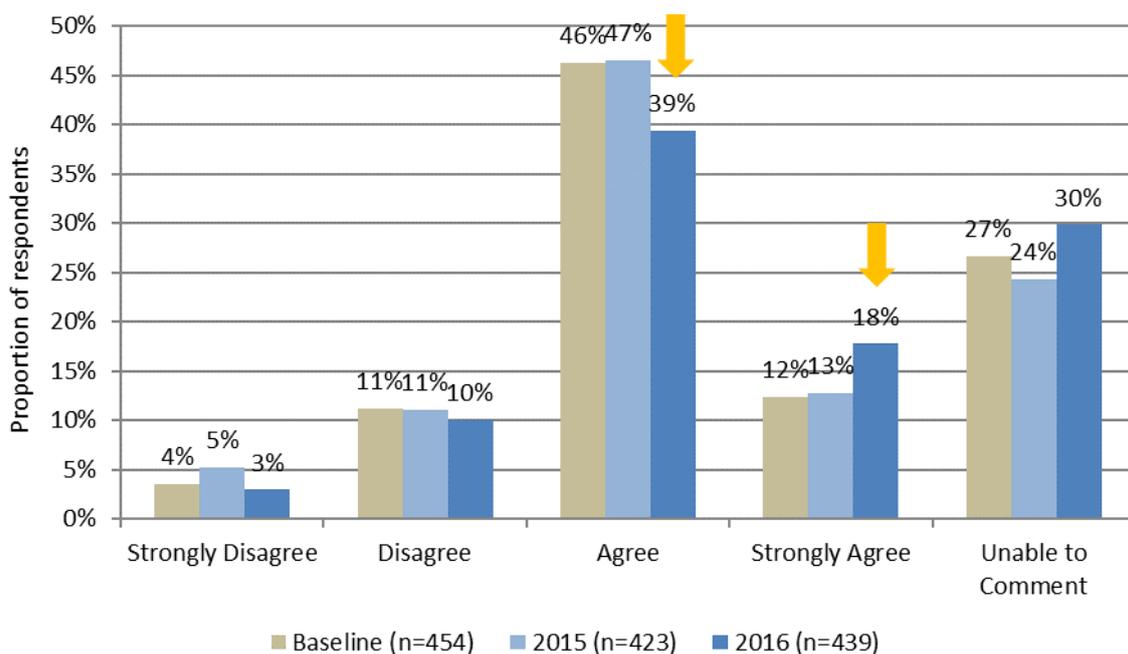


3.3.5 Customer focus

This section presents the survey results related to the extent to which the QMHC is operating with a customer focus and incorporating the views and input of key stakeholders to inform its planning and decision making.

With respect to whether the QMHC is utilising the views of people with lived experience, their families, carers and support people, Figure 50 shows that the overall proportions of respondents agreeing (~60%) compared to disagreeing (~14%) remained approximately constant across years. However, the most recent survey suggests a strengthening of agreement, with 8% fewer respondents agreeing with the statement while 5% more respondents strongly agreed with the statement.

Figure 50: “The QMHC is utilising the views of people with lived experience, their families, carers and support people to inform planning and decision making.”– over time



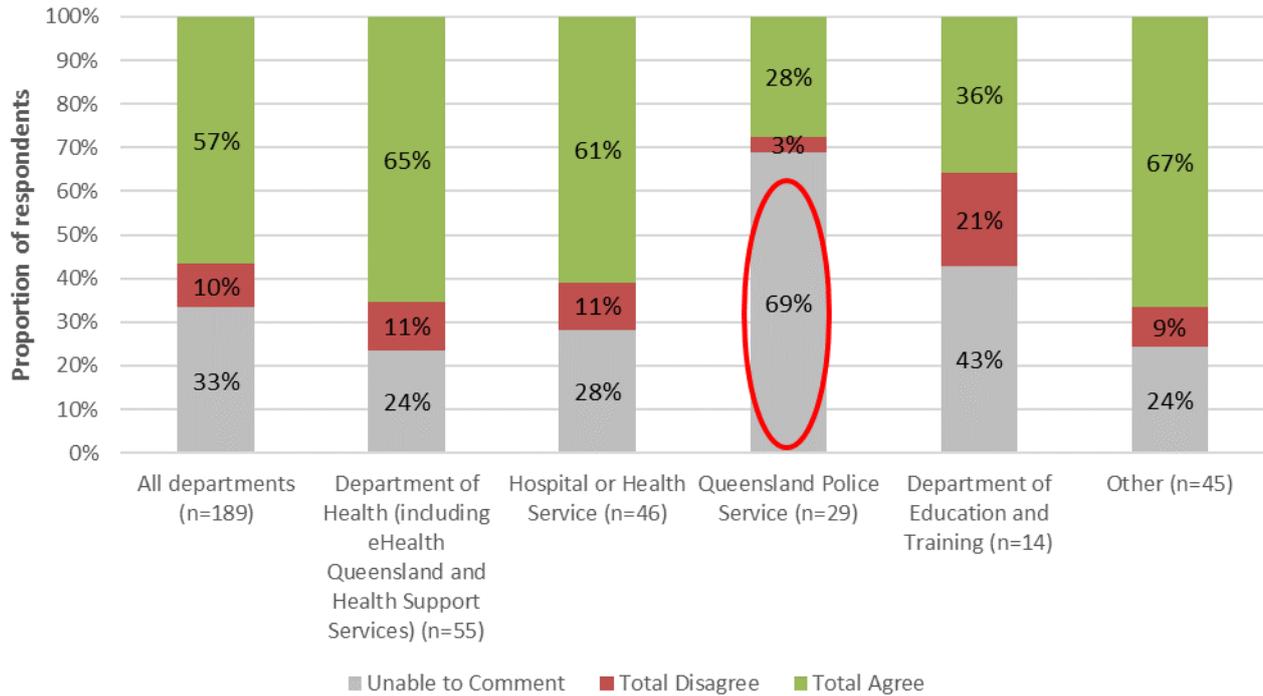
The majority of 2016 respondents, irrespective of personal role, agreed that the QMHC is utilising the views of people with lived experience, their families, carers and support people to inform planning and decision making (Figure 51). Teachers had the lowest level of agreement (52%), while 36% of respondents identifying as Queensland state government employees reported being unable to comment on the question.

Figure 51: “The QMHC is utilising the views of people with lived experience, their families, carers and support people to inform planning and decision making.” – by personal role



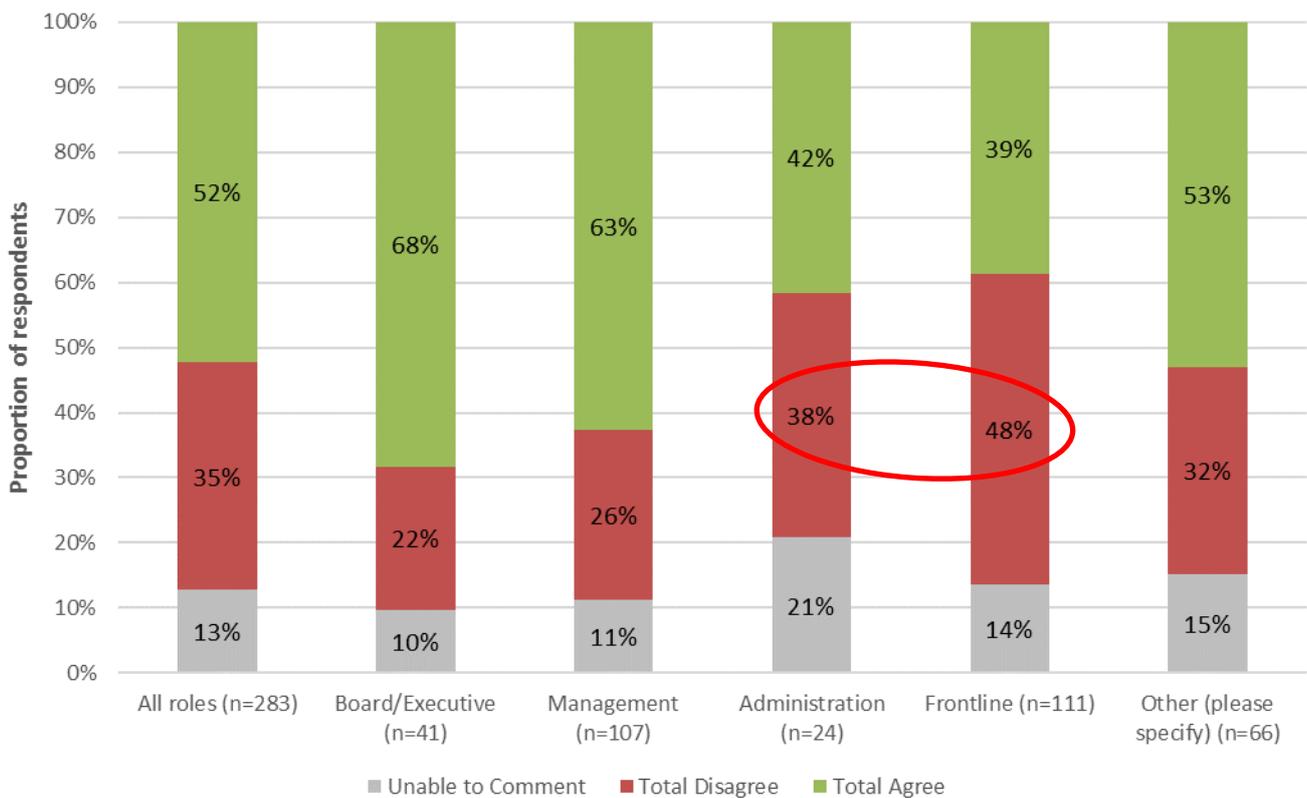
Over two-thirds of 2016 respondents identifying as Queensland Police Service employees reported being unable to comment on whether the QMHC was utilising the views of consumers, families and carers to inform planning and decision making (Figure 52). This suggests that this group may be least aware of the QMHC’s planning and decision making processes.

Figure 52: “The QMHC is utilising the views of people with lived experience, their families, carers and support people to inform planning and decision making.”– by department



Unlike Board/Executive and Management respondents where over 60% of respondents agreed that the QMHC is utilising the views of consumers, families and carers, only around 40% of respondents identifying as Administration or Frontline staff agreed the same.

Figure 53: “The QMHC is utilising the views of people with lived experience, their families, carers and support people to inform planning and decision making.”– by organisational role



The largest proportion of 2016 respondents across all sectors (ranging from 48% to 74%) agreed that the QMHC is utilising the views of consumers, families and carers in planning and decision making. The one exception was for

respondents identifying with the Justice sector of which only 30% agreed, with equal proportions of the remaining respondents (35% each) either disagreeing or unable to comment.

Figure 54: “The QMHC is utilising the views of people with lived experience, their families, carers and support people to inform planning and decision making.” – by sector

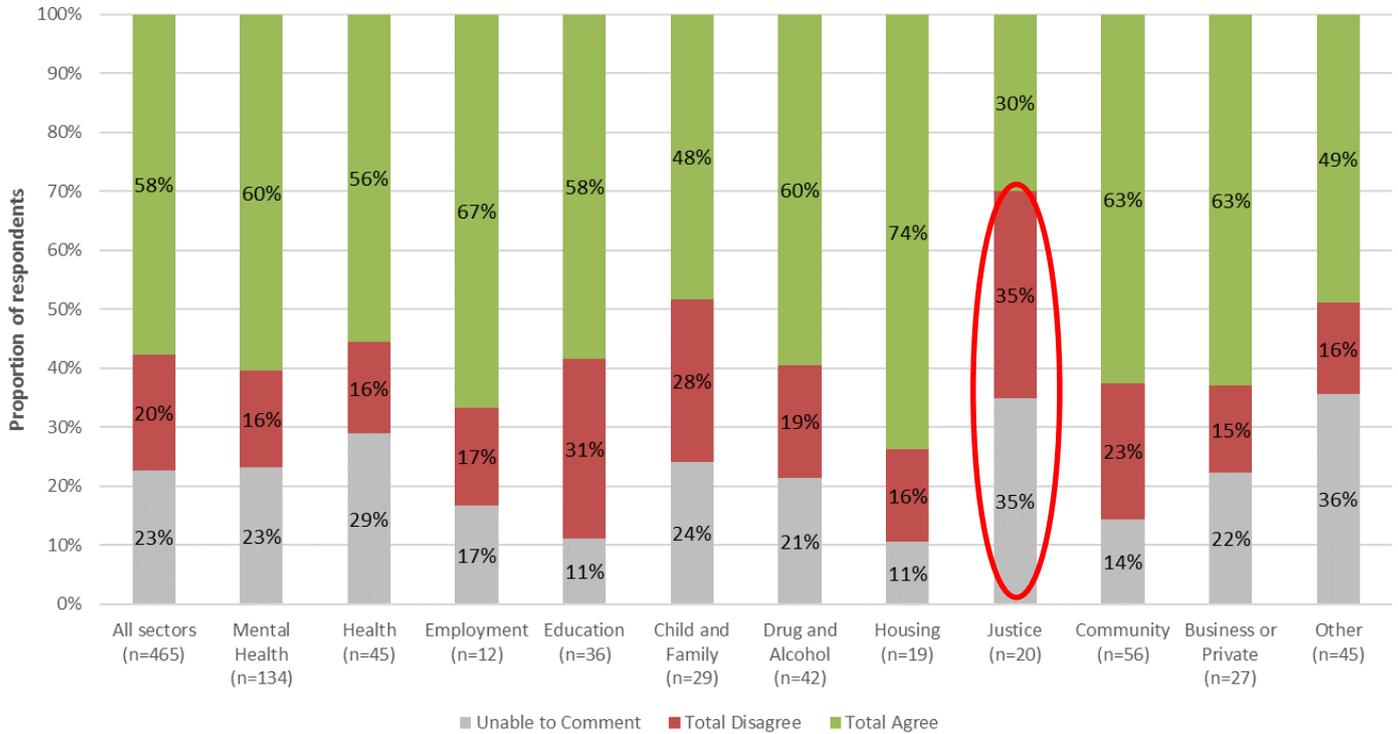
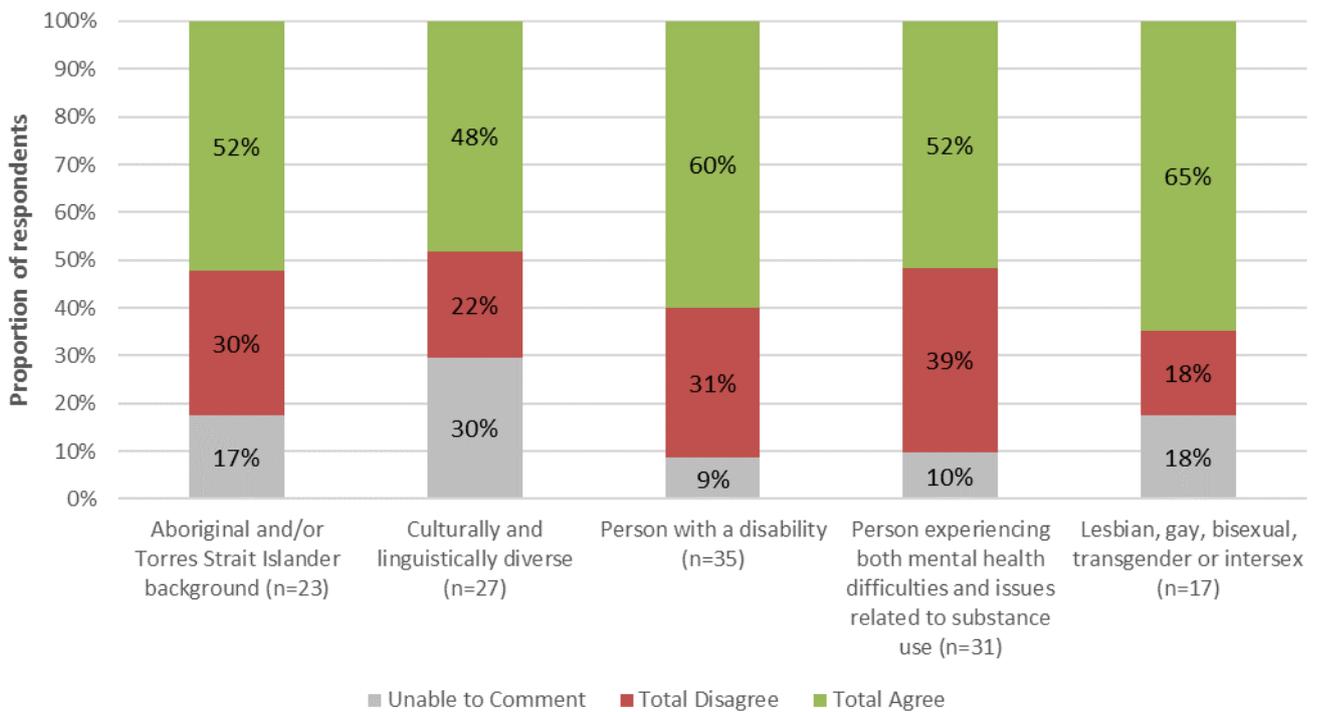


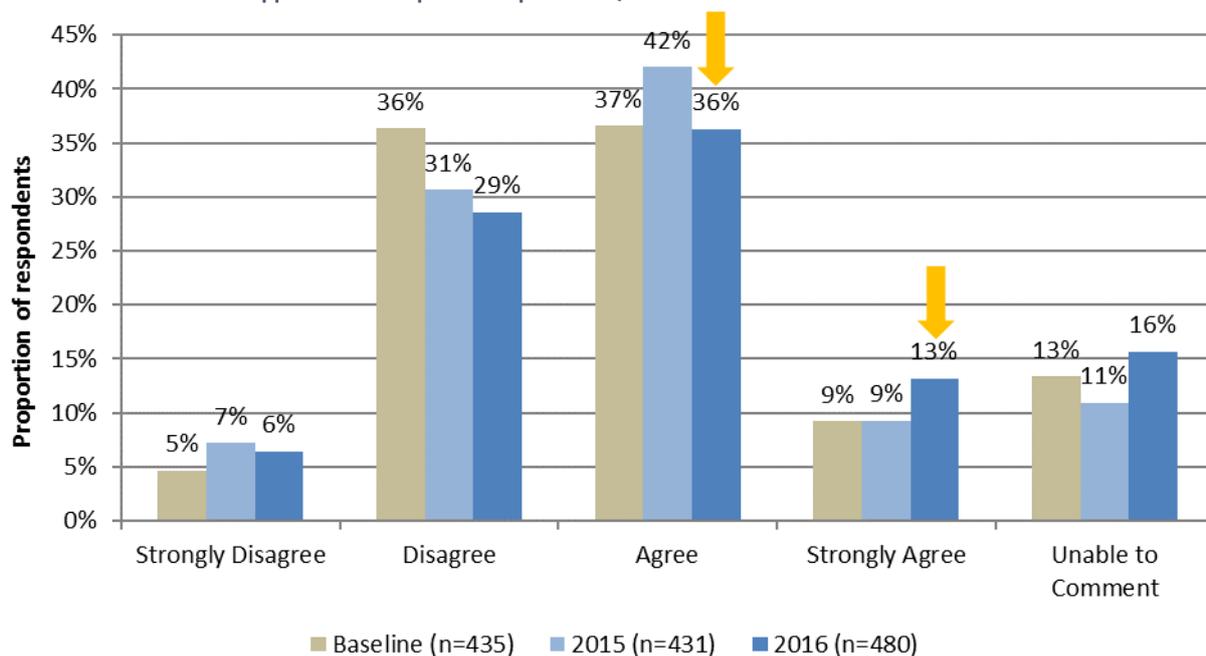
Figure 55: “The QMHC is utilising the views of people with lived experience, their families, carers and support people to inform planning and decision making.” – by priority population



As an additional way to understand the QMHC’s engagement of stakeholders, survey respondents were asked to comment on the extent to which they have had sufficient opportunities to input into QMHC work. Figure 56 shows that across all survey years approximately half of respondents reported having sufficient opportunity to provide input into QMHC work. Notably, in the most recent year, there was strengthening of the level of agreement, with a shift of respondents from reporting that they ‘Agree’ to ‘Strongly Agree’ that they had sufficient opportunity to input into QMHC work.

However, while declining year-on-year, a relatively high proportion of respondents (35% in 2016, compared with approximately 40% in the Baseline and 2015 surveys) still exists that disagree that they had had sufficient opportunity to provide input into QMHC work. This suggests that there is an opportunity to increase the opportunities for stakeholders to input into QMHC work.

Figure 56: “I have had sufficient opportunities to provide input into QMHC work.” – over time



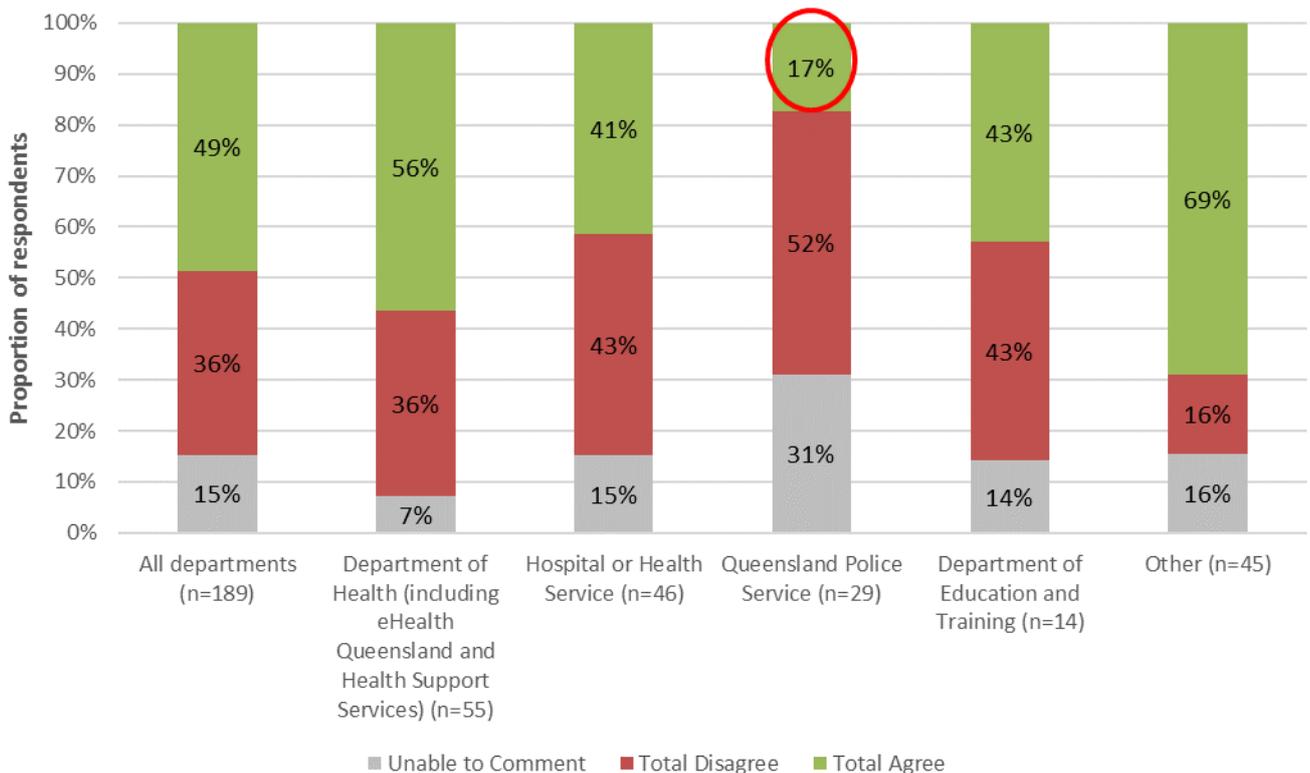
Approximately one-third of respondents, irrespective of personal role, disagreed that they had sufficient opportunities to provide input into QMHC work (Figure 57). This is consistent with the findings in Figure 56, that while the majority of respondents are positive, some work is required across all groups to increase opportunities to provide input into the QMHC’s work. This was more pronounced for teachers where only 19% agreed that they had had sufficient opportunities to provide input into QMHC work. Conversely, over 80% of respondents identifying as university academics agreed that they had had sufficient opportunity to input into QMHC work.

Figure 57: “I have had sufficient opportunities to provide input into QMHC work.”– by personal role



Queensland Police employees were least likely to agree that they had sufficient opportunities to input into QMHC work (17%) (Figure 58). Similarly, the majority of respondents from HHSs (43%) disagreed that they had had sufficient opportunities to input into QMHC work. This, taken with other survey results, suggests a need to develop new and additional strategies to engage with HHSs and Queensland Police and provide them with opportunities to input into QMHC work.

Figure 58: “I have had sufficient opportunities to provide input into QMHC work.”– by department



The majority of Board/Executive (68%) and Management (63%) respondents agreed that they had had sufficient opportunities to input into QMHC work. In contrast, only approximately 40% of Administration and Frontline staff indicated having sufficient opportunities to provide input into QMHC work, suggesting that these groups would benefit from additional engagement opportunities.

Figure 59: “I have had sufficient opportunities to provide input into QMHC work.”– by organisational role

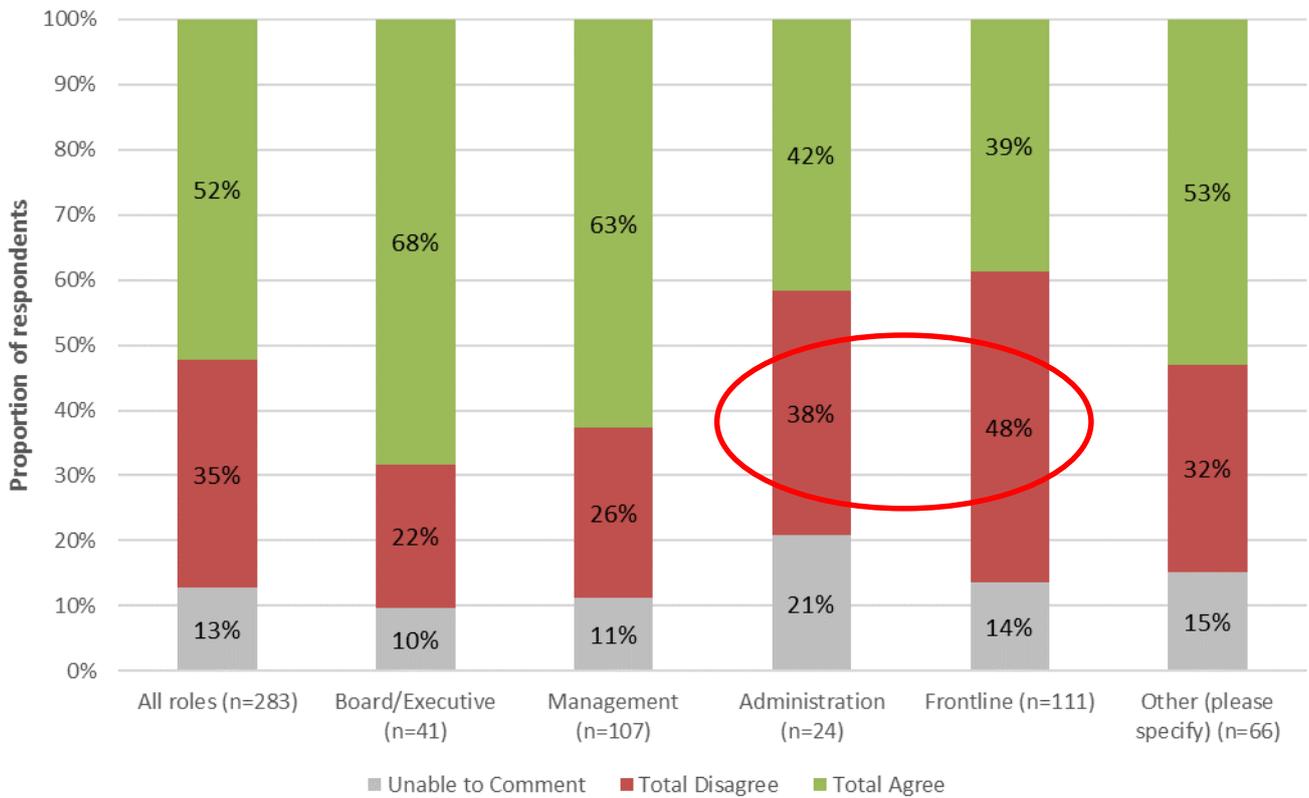


Figure 60: “I have had sufficient opportunities to provide input into QMHC work.”– by sector

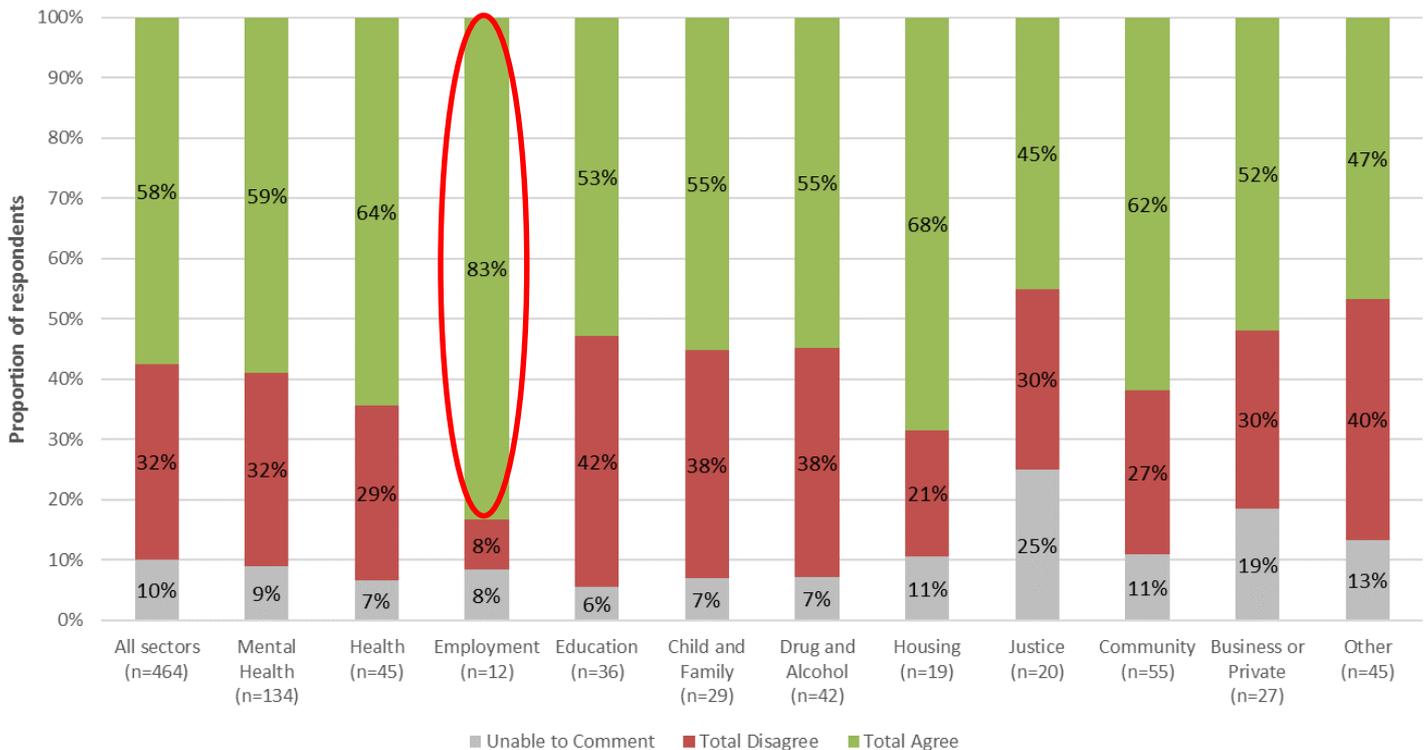
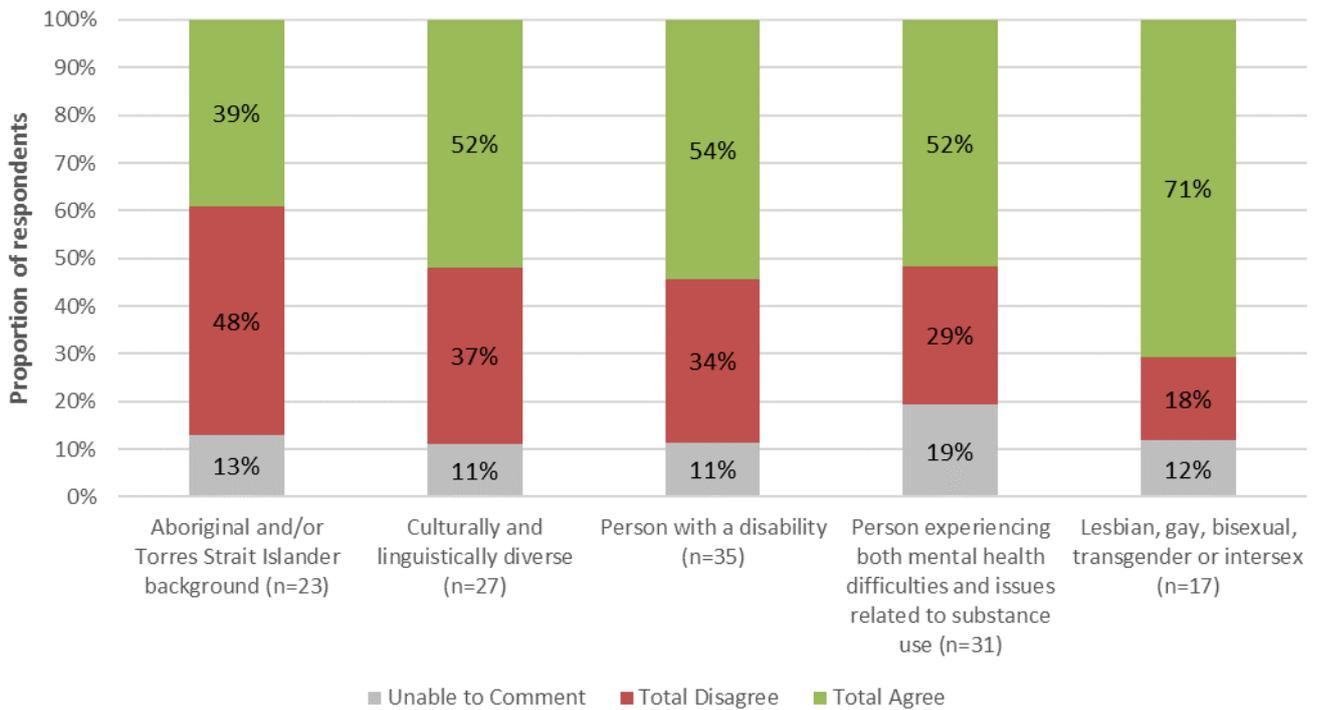
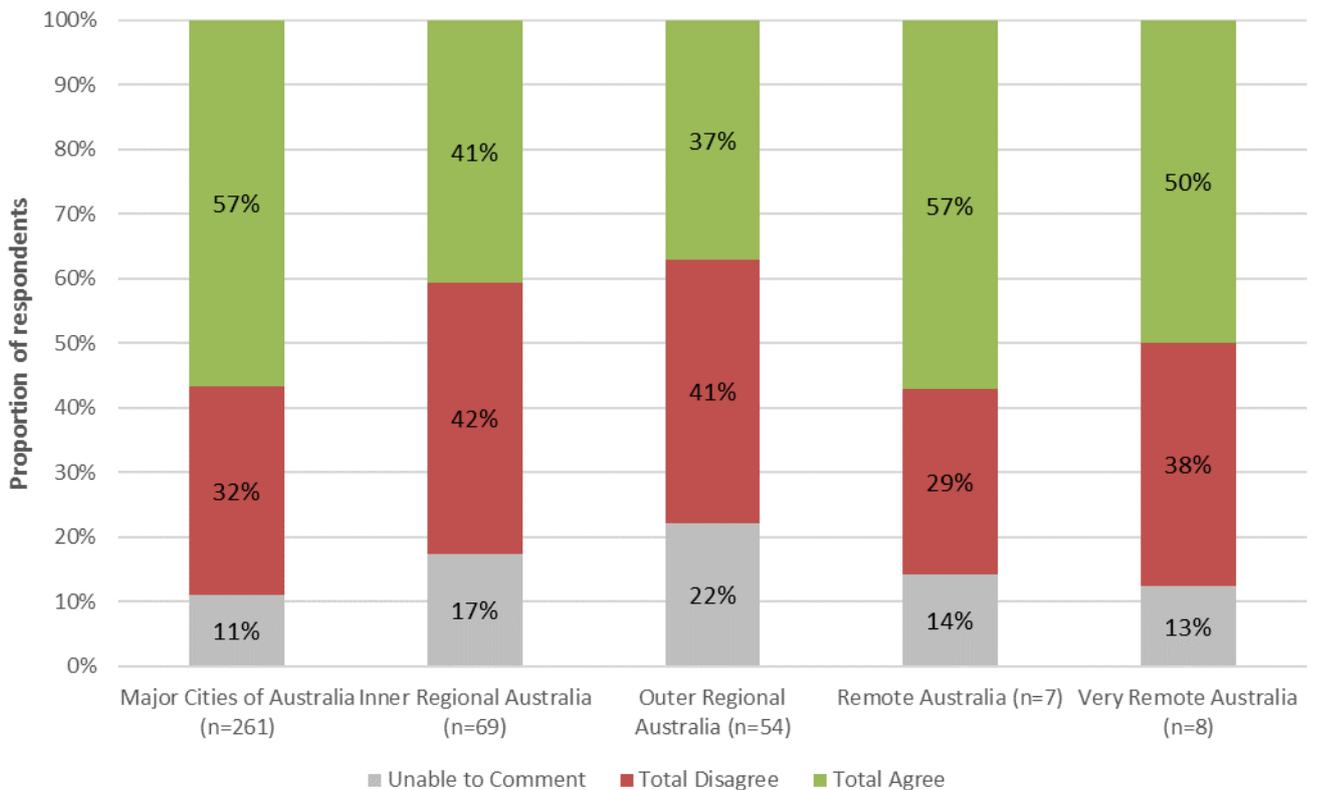


Figure 61: “I have had sufficient opportunities to provide input into QMHC work.”– by priority population



Over half (57%) of respondents from Major Cities reported having sufficient opportunities to provide input into QMHC work (Figure 62). This proportion reduced to approximately 40% for respondents from either Inner Regional or Outer Regional Australia, suggesting that a greater focus on regional Queensland may be required.

Figure 62: “I have had sufficient opportunities to provide input into QMHC work.”– by rurality



3.4 Collaboration

The achievement of the Shared Commitments described in the Strategic Plan, by definition, require the contribution of multiple stakeholders. This includes, in many cases, various Queensland government departments; recognising the multiple, often complex, service needs of people experiencing mental illness and/or substance misuse issues.

The Commission has successfully worked in partnership with various government departments, providing expertise, leadership and support, toward addressing the common goals specific to individual initiatives (see Final Stage 2 QMHC Evaluation Report). However, to drive long-term sustainable reform, the Commission must build effective collaborations with government and other bodies towards achieving, not just the goals of targeted activities, but the broader outcomes articulated in the Strategic Plan.

Table 3 (adapted from Himmelmann⁵) outlines the progressive stages of maturity of collaboration. This framework provided a key reference point for the QMHC Evaluation Framework design. While collaboration is not always required for effective partnerships, nor possible given the high resource requirements and time for development, for many of the Commission’s objectives, collaboration with multiple parties will be required to ensure sustainability.

Table 3: Stages and attributes of Collaboration

Stage	Definition	Attributes	Typical application
Networking	“exchanging information for mutual benefit”	Does not require much time or trust nor the sharing of turf	Networking is a very useful strategy for organisations that are in the initial stages of working relationships
Co-ordinating	“exchanging information for mutual benefit and altering activities for a common purpose”	Requires more time and trust but does not include the sharing of turf	Co-ordinating is often used to create more user-friendly access to programs, services, and systems
Co-operating	“exchanging information, altering activities, and sharing resources for mutual benefit and a common purpose”	Requires significant amounts of time, high levels of trust, and a significant sharing of turf	Co-operating may require complex organisational processes and agreements in order to achieve the expanded benefits of mutual action
Collaborating	“exchanging information, altering activities, sharing resources, and a willingness to enhance the capacity of another for mutual benefit and a common purpose”	Requires the highest levels of trust, considerable amounts of time, and an extensive sharing of turf	Collaboration also involves sharing risks, resources, and rewards and, when fully achieved, can produce the greatest benefits of mutual action

While difficult to assess empirically, the 2016 Evaluation survey was adapted with a series of new questions (Q11 and Q12) to attempt to determine the effectiveness of the QMHC in forming effective partnerships with the range of stakeholders that will be required to deliver on the Shared Commitments to Action in the Strategic Plan.

Figure 63 plots the number of respondents according to their perception of the current level of collaboration between their organisation and the QMHC and the extent to which they agree that the current level of collaboration is sufficient to achieve their organisation’s strategic goals.

⁵ Himmelman, A., (2001). On coalitions and the transformation of power relations: collaborative betterment and collaborative empowerment. *American Journal of Community Psychology*, 29, 277-284.

Figure 63: Current level of collaboration with QMHC vs agreement that current level of collaboration is sufficient (n=233)



In broad terms, the respondents can be categorised into four groups:

- **Group 1:** No/low level of collaboration and don't agree that this is sufficient
- **Group 2:** No/low level of collaboration and agree that this is sufficient
- **Group 3:** Mid-high level of collaboration and agree that this is sufficient
- **Group 4:** Mid-high level of collaboration and don't agree this is sufficient

Unsurprisingly, respondents in Group 1 (no/low current collaboration with QMHC) were least likely to agree that this was sufficient. The QMHC has the most work to do with these stakeholders to improve their level of collaboration. Conversely, those in Group 3 were most likely to agree their current level of collaboration with the QMHC (co-ordinating/co-operating/collaborating) was sufficient.

Group 2 represent an interesting group in that these respondents (particularly those indicating their current level at "Networking"), appear content that this level of collaboration is sufficient to achieve their strategic goals. This is encouraging and supports the notion that a high degree of collaboration may not be required in all cases to achieve Collective Impact. Only a very small proportion (less than 5%) of respondents indicated that no collaboration with the QMHC is necessary to achieve their strategic goals.

Only a small number of respondents fell into Group 4. That is, they felt that there was a reasonable degree of co-operation/co-ordination or collaboration, but still saw this as insufficient to meet their current strategic goals. The QMHC should engage with this group to plan how to progress from co-ordination/co-operation to collaboration, with a view to having these respondents move into Group 3 in the future.

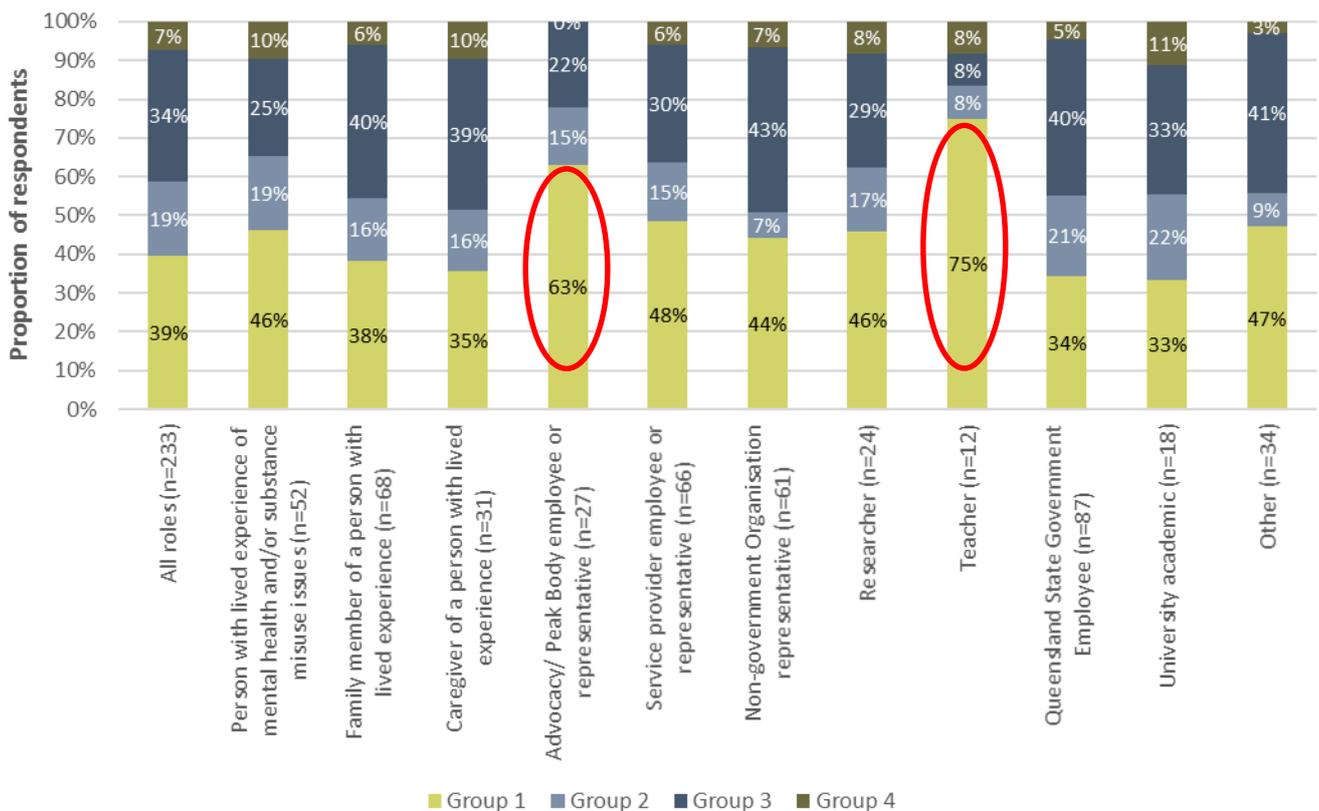
Overall, these results suggest that survey respondents view collaboration with the QMHC as key to achieving their strategic goals. This is further supported by the fact that the majority (82% overall) of respondents to Question 12b reported collaboration with the QMHC as being essential to achieving their organisation's future strategic

goals, irrespective of current level of collaboration (data not shown). The figures that follow in this section present the proportion of respondents fitting into each group depicted in Figure 63.

Over half (53%) of respondents (irrespective of personal role) fell into Groups 2 and 3 (Figure 64), suggesting that a slightly greater proportion of respondents across all levels of current collaboration agreed that their current collaboration is sufficient to achieve their organisation’s goals. Encouragingly, this finding held true for respondents identifying as family members (56%) or caregivers (55%) of a person with lived experience. Although this proportion was slightly lower (44%) for people with lived experience themselves.

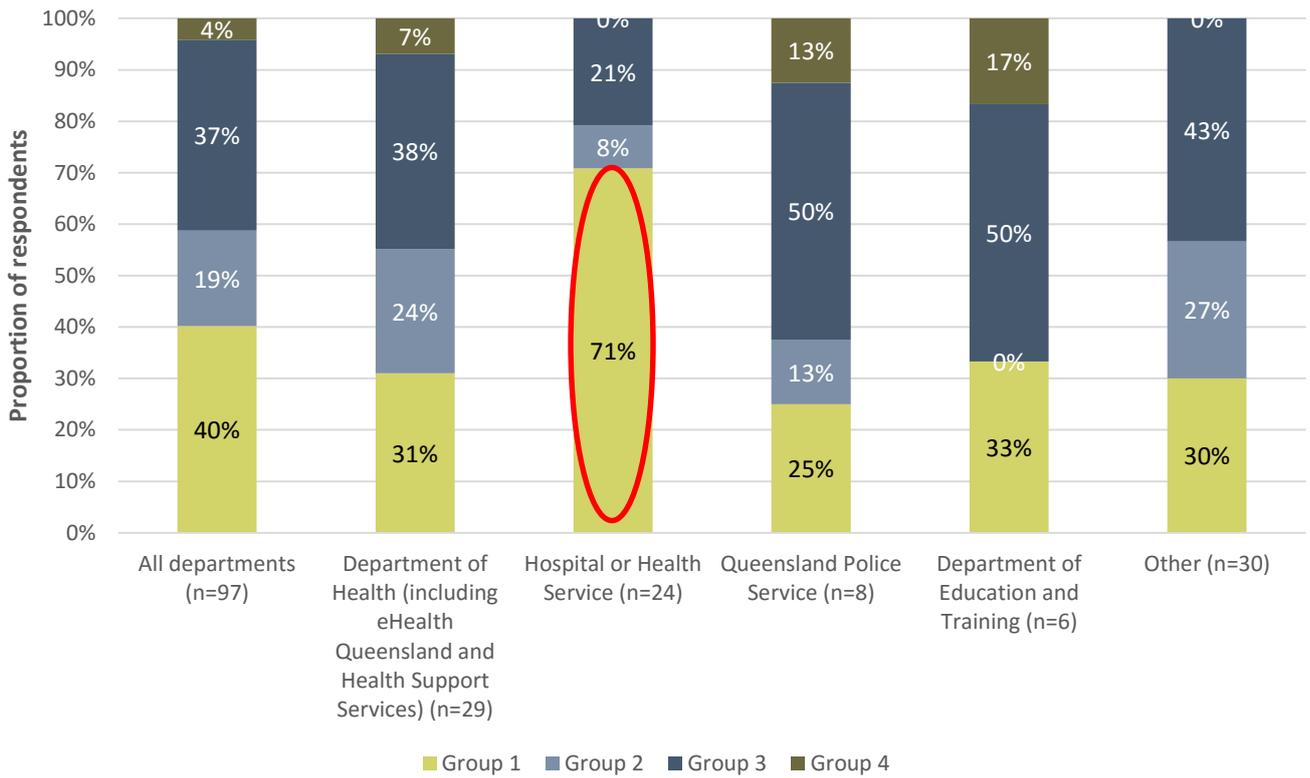
There were two other notable exceptions in that 75% of respondents identifying as teachers, and similarly 63% of ‘advocacy/Peak Body employee or representatives’, fell into Group 1. While overall respondent numbers were low for these two groups (12 and 27, respectively), this suggests a need for improved engagement with, and promotion of the role of the QMHC, amongst these groups.

Figure 64: Proportion of respondents in each group – by personal role



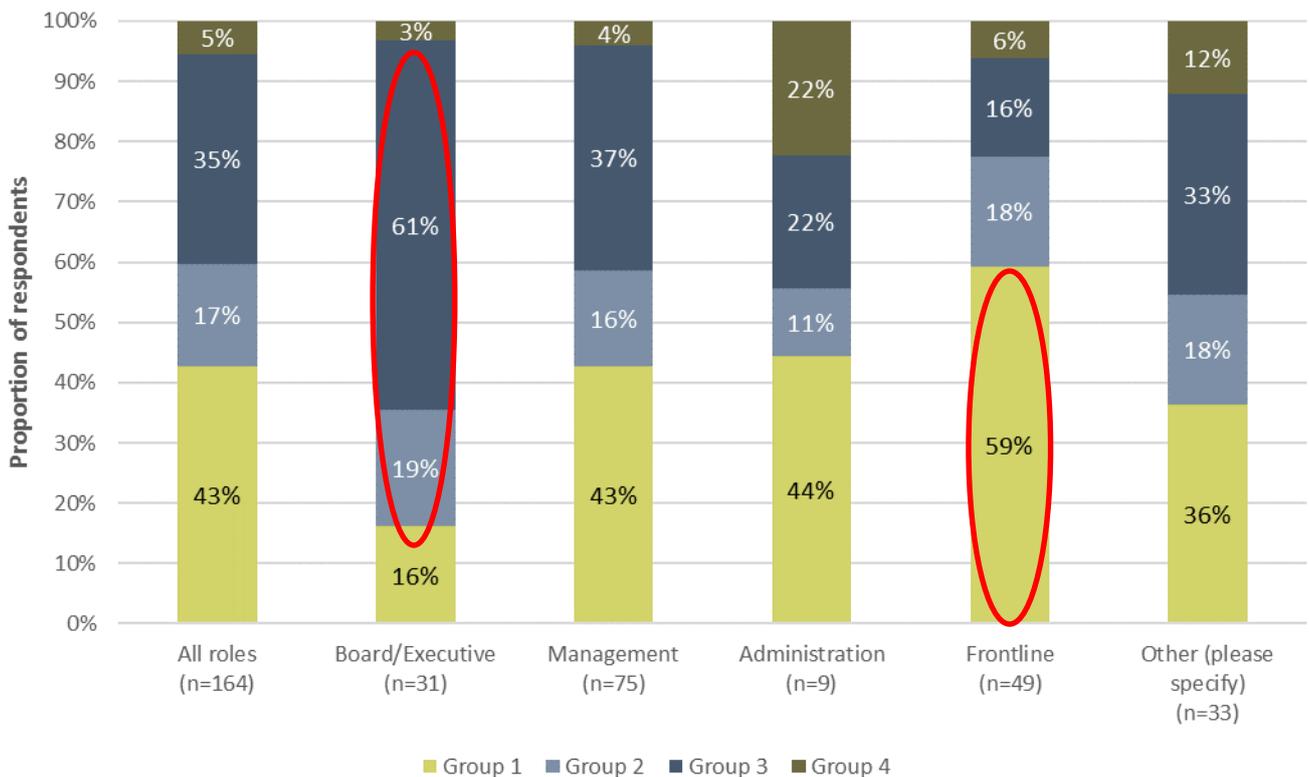
For respondents identifying as QLD government employees, again over half of all respondents fell into Groups 2 and 3. However, over two-thirds of respondents identifying as employees of hospital or health services fell into Group 1 suggesting that there is a need for the QMHC to improve collaboration with these key stakeholders. This finding is consistent with stakeholder consultations undertaken for the Stage 1 (2014) and Stage 2 (2015) evaluation reports that suggested more engagement at the HHS level is required. The volumes of respondents in other department groups are too small to comment on.

Figure 65: Proportion of respondents in each group – by department



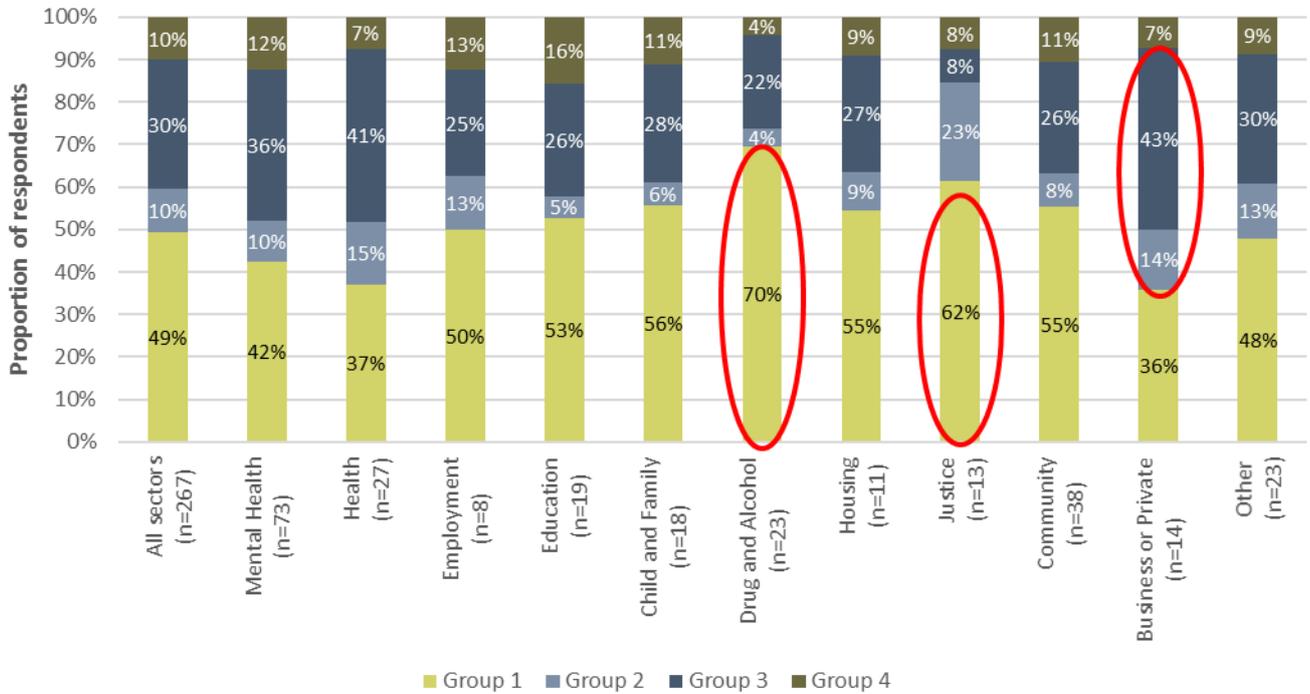
The majority of respondents (80%) identifying as Board/Executive fell into Group 2 or 3. However, respondents identifying their organisational role as “Management” or “Frontline” were most likely to fall into Group 1 (Management: 43%; Frontline 59%). Engagement with these organisational levels remain an area for further improvement.

Figure 66: Proportion of respondents in each group – by organisational role

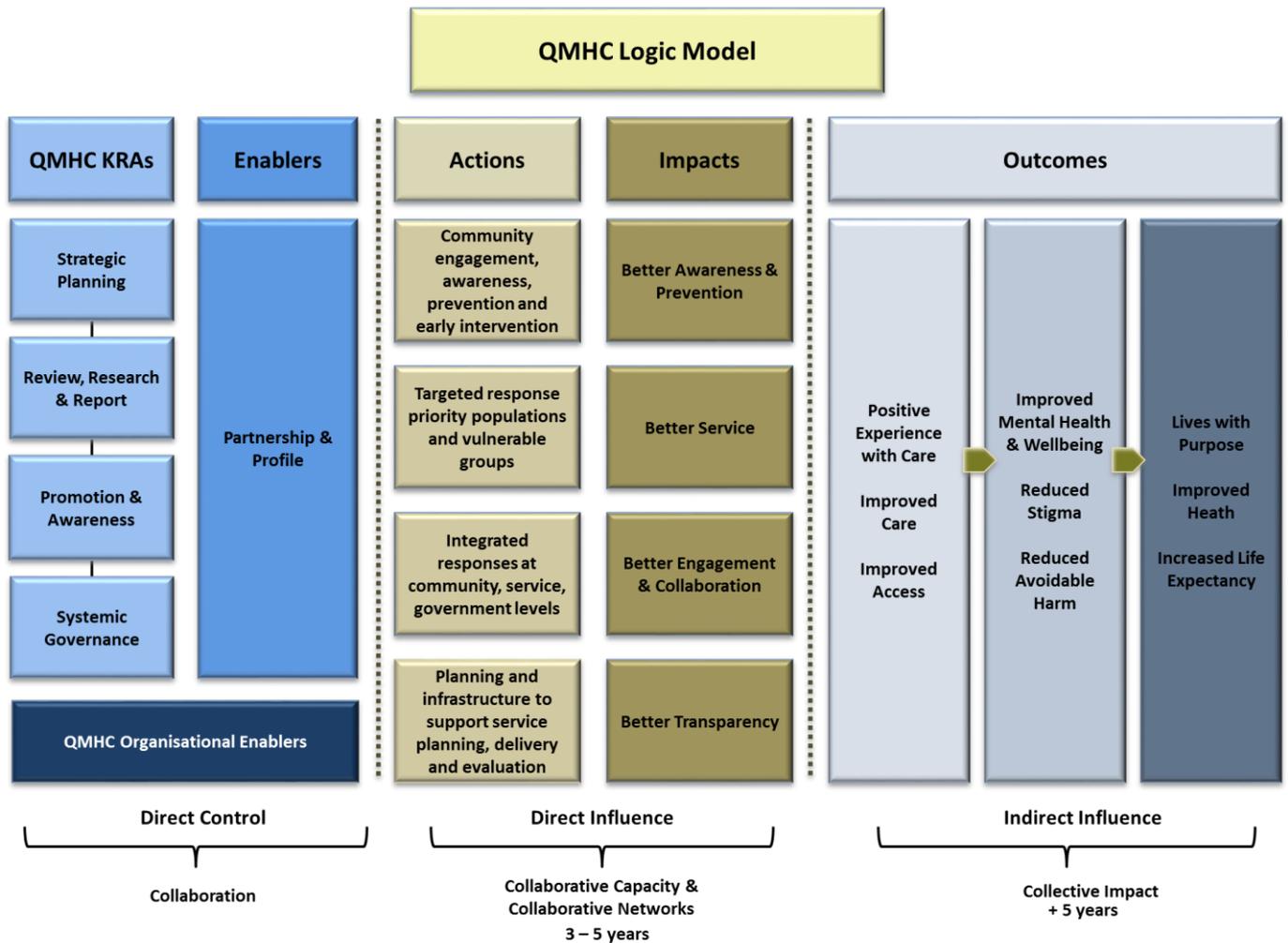


The proportion of respondents by sector (Figure 67) falling into Group 2 and 3 was typically lower than for other categorisations and ranged from a low of 26% (Drug and Alcohol) to a high of 57% (Business or Private). Approximately half of respondents from the mental health sector (46%) and the broader health sector (56%) fell into Group 2 or 3, suggesting that there are a substantial proportion of stakeholders within these key sectors that feel a need for increased collaboration with the QMHC to achieve their goals.

Figure 67: Proportion of respondents in each group – by sector



Appendix A – QMHC Evaluation Logic Model



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