PAXTON PARTNERS

Queensland Mental Health Commission

Evaluation Methodology Development

Final Stage 2 Report

August 2015

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Disclaimer:

This report is prepared solely for the purpose set out in Section 2.1 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 3.

Direct quotes in this report have in most cases been included unedited from their original form.

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Acknowledgement

Paxton Partners would like to thank expressly all those who responded to the evaluation surveys, provided feedback following QMHC events, contributed to the discussion on the QMHC Facebook page, and gave up their time to provide their valuable input in direct one-on-one interviews.

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, drug and alcohol service system.

1. Executive Summary

1.1 Summary of key findings

During the 2014/15 period, the Commission has expanded on the foundation it built during its first year of operation and appears to have made progress on many of the key evaluation indicators assessed.

While the Commission's first year (2013/14) focused on broad consultation and engagement across Queensland to support the development of the Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019, the 2014/15 year has seen the Commission not only release the Strategic Plan, but lead and facilitate a range of key specific initiatives. In doing so, it has formed working relationships with various Queensland Government Departments, peak bodies and agencies and other Mental Health Commissions around Australia. This reflects a maturation of the Commission's relationships and activities suggesting it is moving to the role of coordinating and cooperating with other governmental areas particularly in critical initiatives.

Further reflecting an increase in government commitment, the internal resourcing of the Commission has improved significantly over the last year in terms of composition, structure and focus with concrete plans to monitor and manage the Commission's culture on an ongoing basis. There is early evidence that this may be contributing to improve effectiveness through improved internal coordination. However, like all quality improvement activities, there remain opportunities to strength capacity and governance, actions supported by stakeholder feedback, including the possible addition of a Deputy Commissioner, as in the NSW and National Mental Health Commissions.

Guiding the new tranche of activity is the Strategic Plan, that the majority of survey respondents noted identifies priorities that are important to them and that, at least to some extent, articulates a clear direction. However, while most stakeholders felt the Strategic Plan was comprehensive and well compiled, many also felt it lacked concrete actions that could be readily implemented and saw an Action or Operational Plan (or Plans) as being essential to its translation into practice. Not surprisingly, despite feeling positive it would effect change in the future, most stakeholders felt it was too early to tell if the Strategic Plan would be effective and expected at least 3-5 years would be required for impacts to be observed.

The various targeted initiatives, promotion and awareness activities (e.g. engagement initiatives, website, Facebook), and products (e.g. research reports) are most likely contributing to the fact that almost 75% of survey respondents indicated being at least moderately familiar with the work of the Commission. The Commission is seen to be engaging a wide range of stakeholders who, largely, report having had sufficient opportunity to provide input to the work. While this has improved since the Baseline, there still is room for broader awareness of the Commission, particularly the role of the Mental Health and Drug Advisory Council. Related to this is the increased engagement of stakeholders and persons with lived experience, but the need to increase the translation of the voices of stakeholders and those with lived experience into the work. This is particularly true of stakeholders from multicultural, rural and remote backgrounds and people with a disability.

While the Commission appears to have strengthened its own partnerships with stakeholders across multiple sectors it must also assist in fostering independent networks and collaborations between multiple departments and organisations to ensure ongoing sustainability and collective impact as an effective "Backbone Organisation". Fostering collaborations to extend beyond specific initiatives will help to translate the strategic plan to action.

Encouragingly, the QMHC is seen as credible by most stakeholders. However, it was not always seen as sufficiently independent from the QLD Health and Government, which some stakeholders identified as a perceived barrier to its ability to achieve real change. This will be an interesting tension for the QMHC to manage as it must engage QLD Health and various government departments in terms of function and ability to operationalise the Strategic Plan and achieve longer-term impacts. To this end, the QMHC has started to address these concerns. It is working to strengthen the Advisory Council with two additional support committees (one focused on ATSI issues, one focused on consumer, family and carer work) and liaising with the Auditor General to investigate ways to improve transparency of spending for mental health, drug and alcohol services. With this said, there is an increase in the perception that people with mental health and/or substance misuse issues are benefitting from the QMHC's work.

The Commission commenced many initiatives during the 2014/15 period that will contribute to the achievement of Collective Impacts for the mental health, drug and alcohol sectors and that are aligned to the evaluation questions in this domain. However, given the state, or recency, of completion of these initiatives it may be too early to measure their impact (particularly the sustainability of any anticipated impact), let alone the extent of the Commission's contribution. The development of a set of indicators (underway) to measure progress towards achieving the Strategic Plan's outcomes will provide a foundation against which to understand Collective Impacts in the coming years. It is worth noting that the majority of 2015 survey respondents (and an increased proportion compared to the Baseline) believe that overall there is positive reform underway in the Mental Health, Drug and Alcohol System.

Encouragingly, the evaluation identified clear indicators that would suggest the Commission is progressing relatively well towards proving its effective as a Backbone Organisation. The table below aligns the key evaluation findings to a series of success measures for Backbone Organisations, identified in the literature.

Key indicators of effectiveness	Example measures of success	Key evaluation findings
Leveraged funding	Ability to catalyse, pool or redirect funding in support of the initiative's common agenda	• Funded multiple partnership initiatives • Developed and administered the Stronger Community Mental Health Wellbeing Grants Program
Indicators of initiative progress	Initiative-level early indicators May be more output/process measures – e.g. number of organisations engaged, knowledge exchange sessions facilitated	• The Commission has increased the number of stakeholders and organisations engaged (increase in numbers registered on stakeholder database) • The Commission facilitated numerous knowledge exchange opportunities
Evidence of systems change	Change in stakeholder attitudes/stories/decisions/behaviours.	• Improvements in stakeholder perceptions of most indicators in annual survey. This included an increase of 10% in the proportion that indicated overall there is positive reform underway • Stakeholder consultations also confirmed that stakeholders agree that the Commission has made progress in the last year
Stakeholder perceptions of backbone value	What would be the impact if the backbone was lost? Which specific contributions are perceived to have the greatest value: • Cultivating a culture of collaboration • Building momentum and accountability • Promoting a data-driven approach • Facilitating creation of a collective voice to affect policy and funding.	• The majority of survey respondents: ○ viewed the Commission as an important driver of reform ○ indicated the QMHC is helping to improve collaboration within and across sectors • Stakeholders saw the Strategic Plan as the first step toward improved accountability for addressing mental health, drug and alcohol issues. However, some saw a need for more work for the QMHC in driving ownership of different elements of the plan by all the responsible sectors. • The Commission is undertaking and contracting key research to inform policy decisions (data-driven approach) • In specific areas and initiatives the Commission is facilitating the communication of a collective voice on key issues.

While still in a relatively early to intermediate level of organisational maturity, the Commission has shown good progress against its core metrics over the last year (see summary table below).

	Percent Total Agree (Unable to comment)		
Key Metric	**2014 (n=590)**	**2015 (n=581)**	**Year on Year Change**
Stakeholder satisfaction			
Stakeholders have sufficient opportunity to provide input (Figure 22)	46% (12%)	51% (7%)	↑
The views of consumers, families and carers inform QMHC work (Figure 41)	59% (26%)	59% (24%)	↔
The full range of stakeholders is being engaged (Figure 20)	38% (35%)	41% (29%)	↑
QMHC functions			
QMHC is building collaboration across sectors (Figure 11)	42% (36%)	49% (29%)	↑
The Strategic Plan priorities are important (Figure 31)	N/A (new question in 2015)	62% (26%)	↔
QMHC is increasing community awareness of mental health (Figure 38)	45% (27%)	56% (22%)	↑
QMHC research, review, report work is relevant (Figure 34)	63% (28%)	67% (22%)	↑
Credibility			
Commission is credible (Figure 13)	68% (19%)	72% (15%)	↑
The Advisory Council provides effective advice (Figure 39)	37% (44%)	48% (37%)	↑
Independence			
QMHC is independent of Government (Figure 14)	45% (26%)	52% (20%)	↑
QMHC is independent of Queensland health and other government agencies (Figure 15)	51% (27%)	55% (21%)	↑
Mental Health and Drug and Alcohol Reform Progress			
Positive reform is underway (Figure 43)	49% (23%)	59% (18%)	↑
Reforms are sustainable (Figure 42)	35% (51%)	48% (39%)	↑

It should be expected that over the coming period (2015/16), with its 2015/16 Operational Plan as a framework, the Commission will continue to solidify its foundational work in building partnerships and driving improved collaboration to support specific initiatives and also systemic change in the mental health and drug sector. The Commission should also further expand its reach to additional stakeholders, and the depth of its engagement with all stakeholders through increasing the focus and quality of its engagement activities.

1.2 Summary of Recommendations

Recommendation	Rationale
QMHC Organisational Enablers	
Recommendation 1: The Commission should work with QLD Health to consider restructuring the QMHC's governance structure to include a Deputy Commissioner (or multiple Deputy Commissioners focusing on specific areas).	• The Commission's governance could be strengthened to assist in spreading the load for the current Commissioner. • Would be consistent with governance of other MHCs.
Recommendation 2: When the MHDAC membership is renewed, consideration should be given to ensure appropriate representation of the needs of CALD communities.	• Some stakeholders expressed that the views and input of people with mental health or alcohol or other drug issues from multicultural communities are not being adequately considered in the work of the QMHC.
Recommendation 3: The Commission should continue to monitor and actively manage its own organisational culture.	• A strong and collegiate internal culture is essential to support the effective operation of the Commission.
QMHC Partnerships	
Recommendation 4: The Commissioner should work with government departments to convene, and engage periodically, a cross-governmental committee (e.g. housing, justice, communities child and family, education, employment) (Directors General) to facilitate discussion on the delivery and ownership of activities under the Strategic Plan.	• Stakeholders saw a need to improve the degree of ownership amongst all sectors that mental health and alcohol and other drug issues are 'everyone's' responsibility (e.g. not just health).
Recommendation 5: The Commission should prioritise the establishment of formal partnerships and complementary work with groups representing CALD communities in Queensland.	• CALD communities reported that they were not as engaged as other groups.
Recommendation 6: The Commission should identify tangible initiatives around which to foster the building of effective communities of practice that include service providers from different sectors to identify, and jointly design solutions to, the key service delivery issues facing their respective service users.	• While there was progress at the policy and government levels, it was identified that there is now a need to drive reform down to the service provision level and assist in fostering greater integration between the various service systems.
QMHC Profile	
Recommendation 7: The Commission should continue to enhance opportunities for consumers, families and carers to engage with, and contribute to, the work of the QMHC.	• As a core part of its mandate, the Commission must ensure that consumers, families and carers are engaged in all its work.
QMHC Key Result Areas	
Strategic Planning	
Recommendation 8: Develop and implement a strategy for targeted dissemination of, and communication around, the Strategic Plan to Frontline service providers.	• Frontline service providers were least likely to have received and read the Strategic Plan.
Recommendation 9: Further promote the message that implementing the Strategic Plan is 'everyone's responsibility'.	• Supports Recommendation 4.
Recommendation 10: Continue to work with partners to deliver the objectives of the Strategic Plan and, where necessary, develop specific Action Plans to assist in clearly defining the activities (and responsible parties) to address	• Implementation of the plan was seen to require more specificity in the form of detailed Action Plans, which are a key component of the Strategic Plan.

Recommendation	Rationale
the shared commitments to action.	
Review, Research and Reporting	
Recommendation 11: Continue to identify and invest in targeted research that builds the evidence base around mental health, drug and alcohol issues.	• The research, review and reporting activities of the Commission were seen as valuable highly relevant and useful in bringing together multiple stakeholders from different sectors to collaborate.
Recommendation 12: Research leading practice approaches for the effective dissemination of knowledge products and develop product-specific strategies for release and communication of all future knowledge products.	• The main gaps identified with respect to the Commission's research products was the effective dissemination to the targeted audiences and wider promotion and awareness of their findings.
Promotion and Awareness	
No recommendations identified at this stage.	
Systemic Governance	
Recommendation 13: The Commission should publish the MHDAC's terms of reference on the QMHC website and communicate its role and function as often as appropriate in other forums to increase awareness.	• Stakeholders were generally unclear of the role of the MHDAC and its relationship and interface with the Commission.
Recommendation 14: The Commission should develop and communicate a simple graphic depicting the relationships between the Commission, the MHDAC (and the ATSI and CFC committees), Minister for Health and QLD Health to improve the wider understanding its role and governance.	• Some stakeholders were unclear of the Commission's broader governance
Recommendation 15: Increase communication about how the QMHC is involving consumers, their families and carers in planning and decision-making.	• While the Commission undertook many initiatives that specifically focused on consumer, family and carer engagement, there was negligible improvement in the proportion of 2015 survey respondents that felt that it was utilising the views of consumers, families and carers to inform planning and decision-making.
Collective Impact	
Recommendation 16: Continue to progress and complete planned initiatives and collect data to allow the key evaluation questions in this domain to be answered in Stage 3 of the QMHC evaluation.	• Too early to measure many collective impacts at this stage.
Recommendation 17: Ensure the performance indicators being designed to assess progress of the Strategic Plan implementation enable measurement of the Collective Impacts achieved.	• These indicators will be key to understanding the effectiveness of the Strategic Plan over the long term.
Recommendation 18: Ensure the Commission continues to collect information relevant to identifying, justifying and communicating its contribution to the achievement of Collective Impacts for the mental health, drug and alcohol sectors.	• It is important that this information continues to be collected and monitored to support not just this evaluation but ongoing communication of the Commission's achievements to government and all the Commission's stakeholders.

2. Evaluation Overview

2.1 Purpose of this report

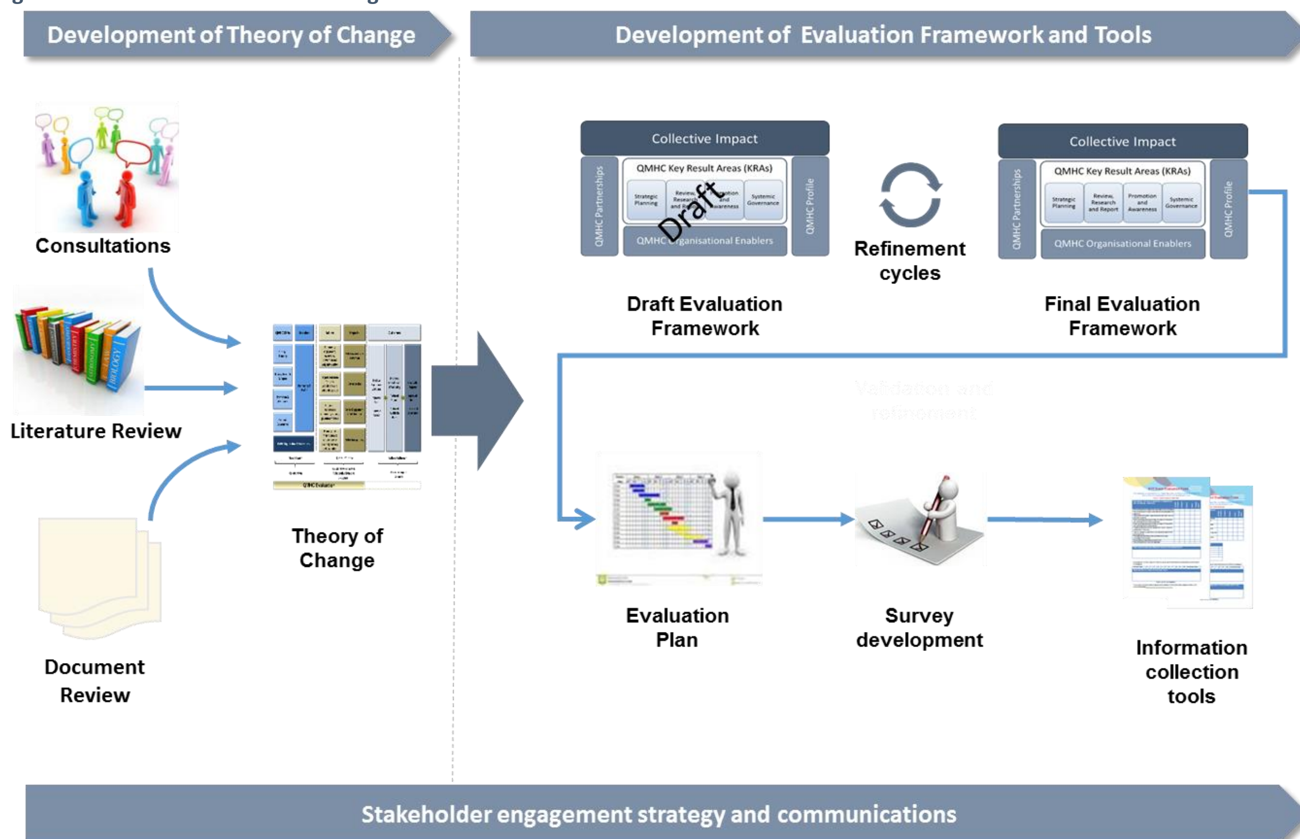
The purpose of this report is to provide an update on the Commission's progress over the last year (2014/15 period) in addressing the recommendations of the Baseline Report and more broadly with respect to the key evaluation questions. This section (Section 2) provides a description of the evaluation design, including design activities, the Theory of Change, and the Evaluation Framework that guides the evaluation process. Section 3 outlines the evaluation implementation activities undertaken to date while Section 4 outlines the key findings from these activities

The report draws from the data sources described in Section 3 and provides a series of recommendations for the Commission to consider in entering the 2015/16 period.

2.2 Overview of evaluation design

The design of the Queensland Mental Health Commission Evaluation was underpinned by the development of a Theory of Change (see Section 2.2.1) informed by an extensive Literature Review[1], stakeholder consultations and review of Queensland Mental Health Commission (referred to as "QMHC" or "the Commission" throughout this report) documentation. This Theory of Change served as the reference point against which to develop the Evaluation Framework (see Section 2.2.2) which 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.

Figure 1: Overview of Evaluation Design Activities

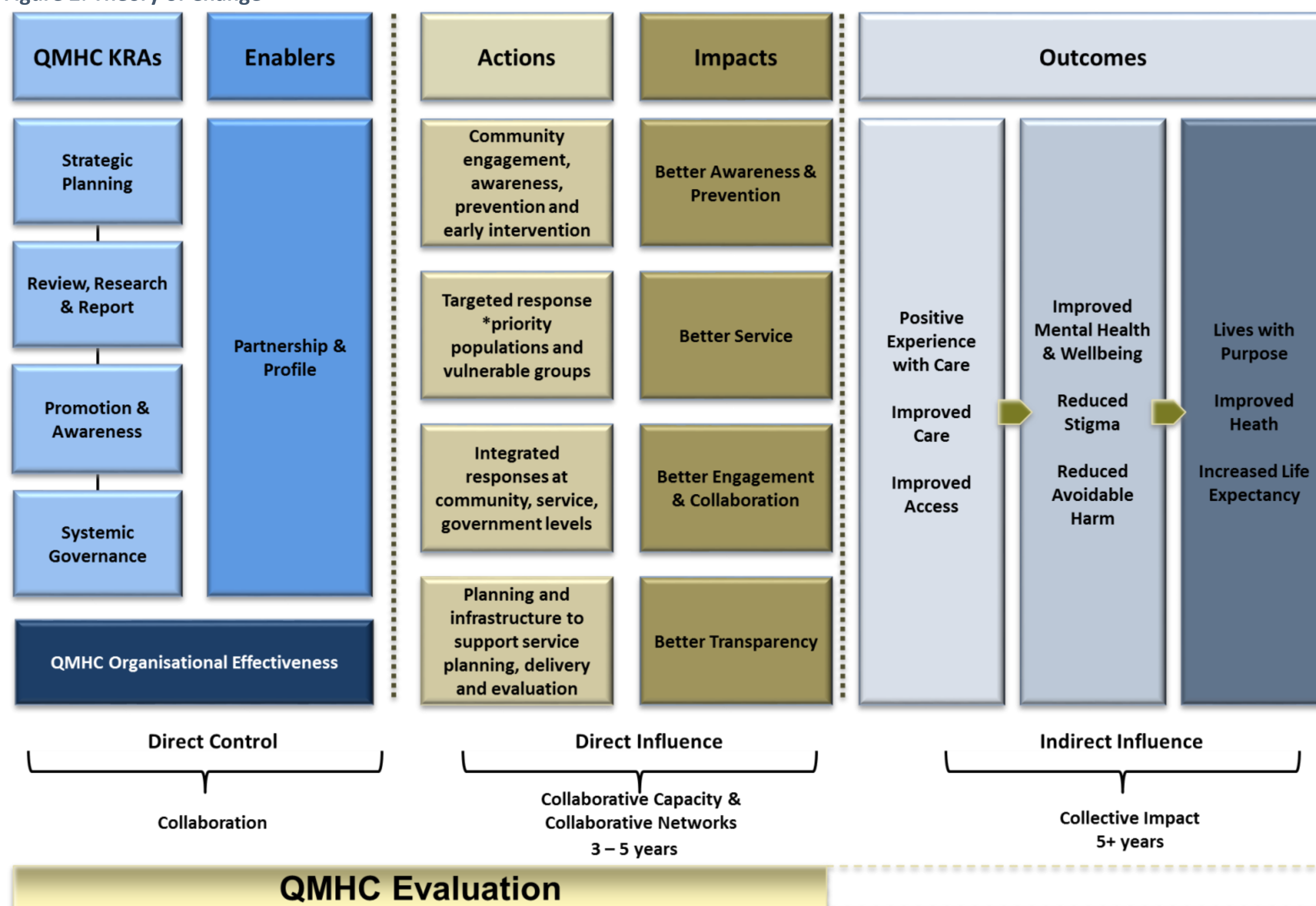


[1] The full Literature Review is available here: http://www.qmhc.qld.gov.au/about-us/our-performance/performance-framework/ , accessed 19 August 2015

2.2.1 Theory of Change

Figure 2 is a visual depiction of the relationships and logical linkages between the QMHC's Key Result Areas (KRAs), attributes, activities, anticipated short-medium term impacts, and longer-term Collective Impacts. The Theory of Change highlights the continuum of control and influence that the QMHC has, in descending order: the activities/actions it undertakes (Direct Control), the impacts it achieves (Direct Influence), and how these contribute to the Collective Impacts for Mental Health, Drug and Alcohol system users (Indirect Influence).

Figure 2: Theory of Change



The QMHC Evaluation focused primarily on the areas that are within the direct control or influence of the QMHC. However, the evaluation also seeks to identify high-level evidence of progress towards achievement of the Collective Impacts that the QMHC is expected to contribute to at a population level (dotted box).

2.2.1.1 The QMHC as a Backbone Organisation

Underpinning the Theory of Change is the concept that the role of the Commission is effectively one of a 'Backbone Organisation'[2] in supporting multiple areas of work with multiple stakeholders that are directed at the common goal of realising improved mental wellbeing and reduced alcohol and other drug misuse.

The indicators of success of effective backbone organisations include:

[2] Turner, S., Errecart, K., & A. Bhatt, A., (2013). Measuring backbone contributions to collective impact." *Stanford Social Innovation Review*. http://www.ssireview.org/blog/entry/measuring_backbone_contributions_to_collective_impact

Table 1: Indicators and measures of effective Backbone Organisations

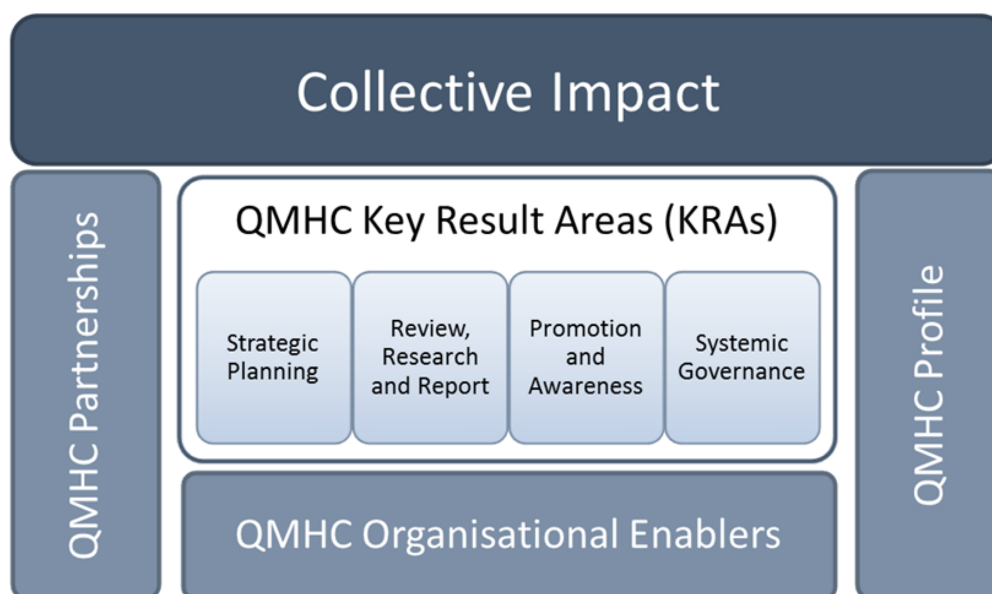
Key indicators of effectiveness	Example measures of success
Leveraged funding	Ability to catalyse, pool or redirect funding in support of the initiative's common agenda
Indicators of initiative progress	Initiative-level early indicators May be more output/process measures – e.g. number of organisations engaged, knowledge exchange sessions facilitated
Evidence of systems change	Change in stakeholder attitudes/stories/decisions/behaviours.
Stakeholder perceptions of backbone value	What would be the impact if the backbone was lost? Which specific contributions are perceived to have the greatest value: • Cultivating a culture of collaboration • Building momentum and accountability • Promoting a data-driven approach • Facilitating creation of a collective voice to affect policy and funding.

While they are likely to be measurable to differing degrees depending on the initiative in question and the role played by the QMHC, the suite of measures above provide a useful reference point for understanding the broader effectiveness of the Commission.

2.2.2 Evaluation Framework

The QMHC Evaluation Framework (Figure 3) 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 3: 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.

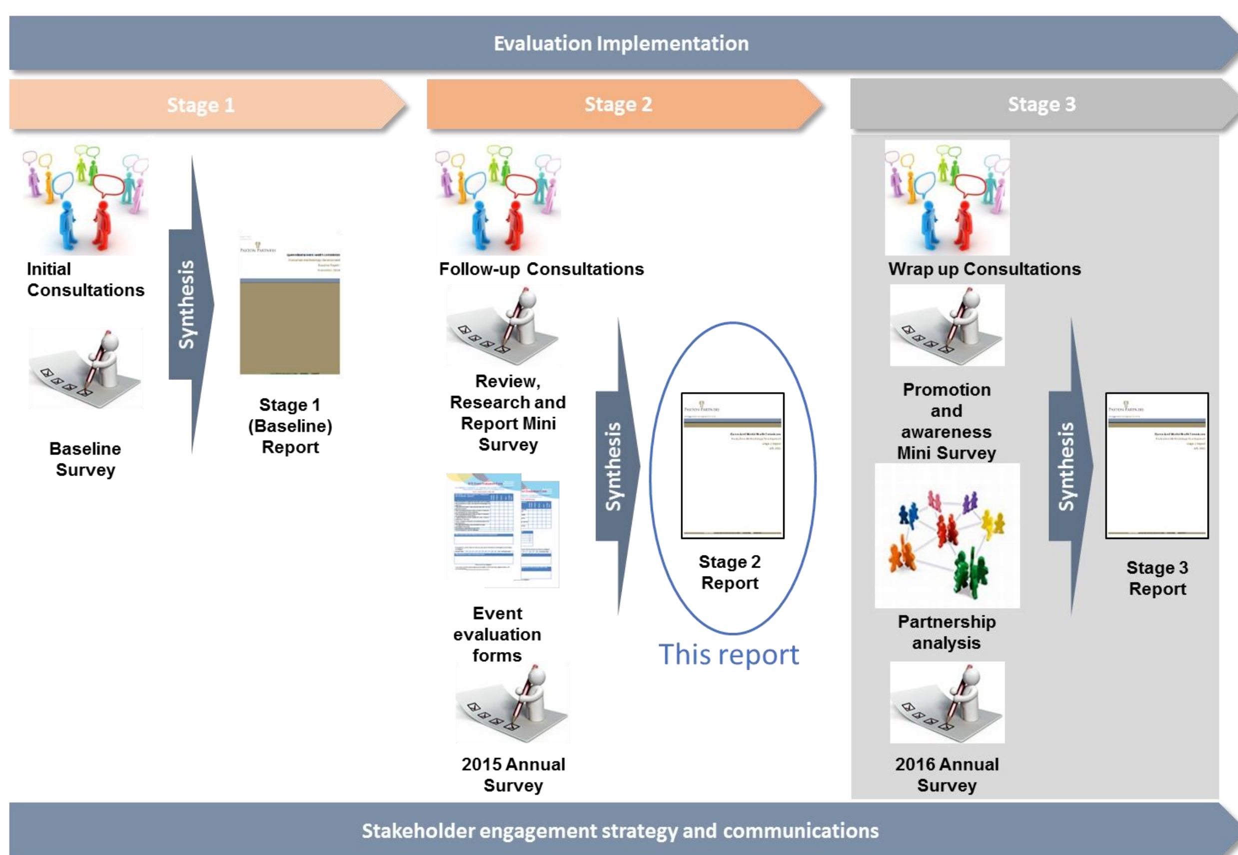
A series of specific evaluation questions (outlined in each sub-section in Section 4) support each of the key domains.

3. Evaluation activities to date

3.1 Overview

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

- **Stage 1[3] (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 since the Baseline findings were reported. 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)**: Planned for the 2015/16 period. This stage will seek 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 will include an attempt to assess the QMHC's impact on improving collaboration within the QLD Mental Health, Drug and Alcohol service sectors, and with other related sectors, as collaboration serves as a key mechanism to achieve collective impacts.



This report focuses on the presentation of results from Stage 2 of the evaluation, and where relevant, comparisons with the Baseline Report. The sub-sections below present a high-level synthesis of the evaluation activities undertaken to date.

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[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

3.2 Stakeholder Consultations

3.2.1 Initial consultations (Stage 1)

Over 20 key QMHC stakeholders were consulted during the early stages of the evaluation. These consultations served two purposes: 1) understanding views on, and expectations for, the QMHC and; 2) informing the development of the QMHC Evaluation Framework.

Six main discussion points guided the consultations:

1. Identification of the needs of the QLD mental health sector that could be addressed by the QMHC.
2. Stakeholder perceptions on the objectives for, and virtues of, setting up the QMHC.
3. The perceived scope of the QMHC's role as an independent provider of leadership and coordination in the QLD mental health, drug and alcohol sectors.
4. The key metrics of success for the QMHC – i.e. what will the QLD mental health sector look like if the QMHC achieves its objectives?
5. The impacts to which the QMHC has contributed and the extent of that the contribution can be identified.
6. Other mechanisms that could be employed to achieve the stated outcomes of the QMHC.

The feedback from these consultations was summarised into six main themes:

1. Role of the QMHC
2. Challenges for the QMHC
3. The Queensland Mental Health, Drug and Alcohol Strategic Plan
4. Utilisation of different levers for change
5. Potential measures of QMHC success
6. Direct experience with the QMHC

The *Summary of Consultation Themes*[4] document developed during Stage 1 presents the findings from this activity.

3.2.2 Follow up stakeholder consultations (Stage 2)

In developing this Stage 2 report, the project team undertook a series of brief follow up consultations with a subset of the stakeholders engaged during the initial consultation phase, to gain their views on:

- The dissemination and quality of the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019*, released in October 2014 (following the Baseline data collection period)
- The degree of progress the QMHC has made in the intervening year since the previous consultation period (approximately July 2014)
- Areas in which the QMHC has an opportunity to improve
- Changes in the broader mental health, drug and alcohol sectors that have been influenced by the QMHC.

Findings from these consultations are referenced throughout Section 4.

3.3 Surveys

3.3.1 Annual survey overview

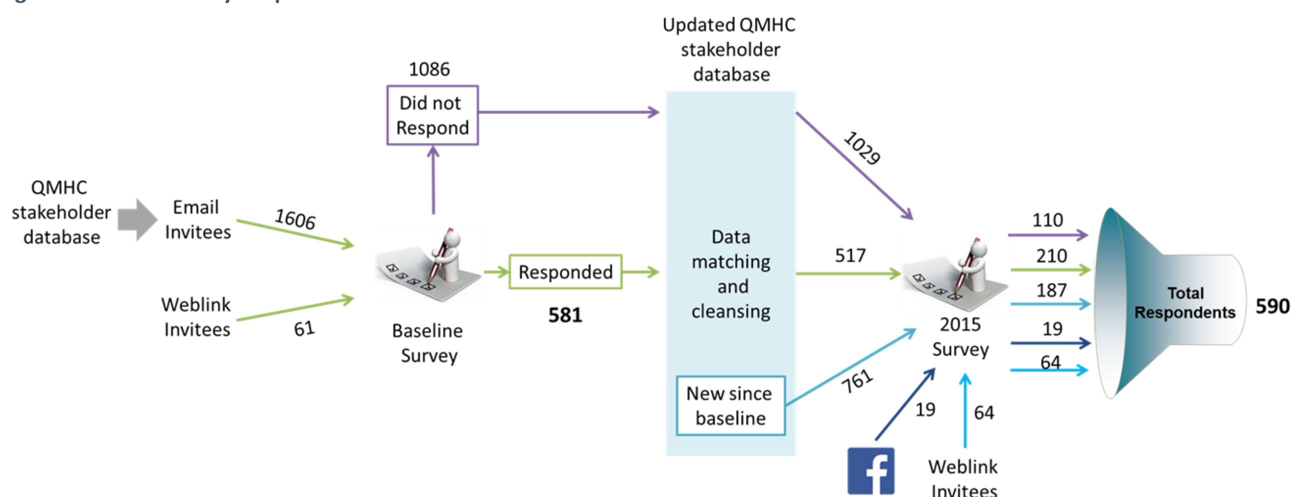
The annual QMHC Evaluation Survey is the main information source contributing to an understanding of impacts and improvements made by the QMHC over time. As the name suggests, it is administered annually to all stakeholders that have engaged with the QMHC, in one form or another, in the preceding year.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

[4] Paxton Partners, QMHC Evaluation, *Summary of consultation themes*

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 (see Appendix A – 2015 Survey questions) 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.

Figure 4 provides an overview of the number of survey invitees, their source, and the number of survey respondents to both the Baseline Survey and the 2015 Survey.

Figure 4: Annual Survey Respondent Flowchart



As Figure 4 shows, the Baseline Survey had an approximately 35% response rate[5] compared to the 2015 Survey which, while achieving slightly higher total respondent numbers (590 vs 581) achieved a lower comparative overall response rate of approximately 25%[6].

2015 survey respondents consisted of five groups:

- Initial non-responders (n = 110)
- Initial responders (n = 210)
- New participants since baseline (n = 187)
- Facebook members (n = 19)
- Weblink invitees (n = 64)

Of all the invitees to the 2015 Survey, the 'stream' with the lowest response rate was the Initial non-responders who were drawn from the QMHC database (just over 10% of the 1029 in this group responded to the 2015 Survey). It is reasonable to speculate that the bulk of this group may be considered 'interested observers' that have signed up to the QMHC's newsletter to keep informed of activities that may be relevant to them or friends, family or colleagues, but are not necessarily directly engaged with the QMHC. These 'interested observers' may be intrinsically less likely, or able, to respond to the survey.

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 the 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.

[5] It was not possible to track how many people were invited to complete the survey via the web-link and therefore the true number of potential respondents is understated, and by extension, the estimated response rate may be slightly higher than actual.

[6] It was not possible to track how many people were invited to complete the survey via the web-link or Facebook and therefore the true number of potential respondents is understated, and by extension, the estimated response rate may be slightly higher than actual.

The sub-section below presents a comparison of the profiles of survey respondents between the Baseline Survey and the 2015 Survey.

3.3.1.1 Profile of Survey Respondents

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

Figure 5 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 respondents was relatively close to the Queensland averages. 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.

> *"Hardly heard of outside of Brisbane!"*
>
> *"…little connection to regional, rural and remote locations…"*
>
> - *2015 Survey respondents*

It should be noted that the Commission commenced a number of specific rural and remote mental health activities in the 2014/15 year, including engaging CheckUP to lead a service integration and referral mapping project (report due mid-2015) and is finalising the draft Rural and Remote Action Plan.

Figure 5: Survey respondents by remoteness

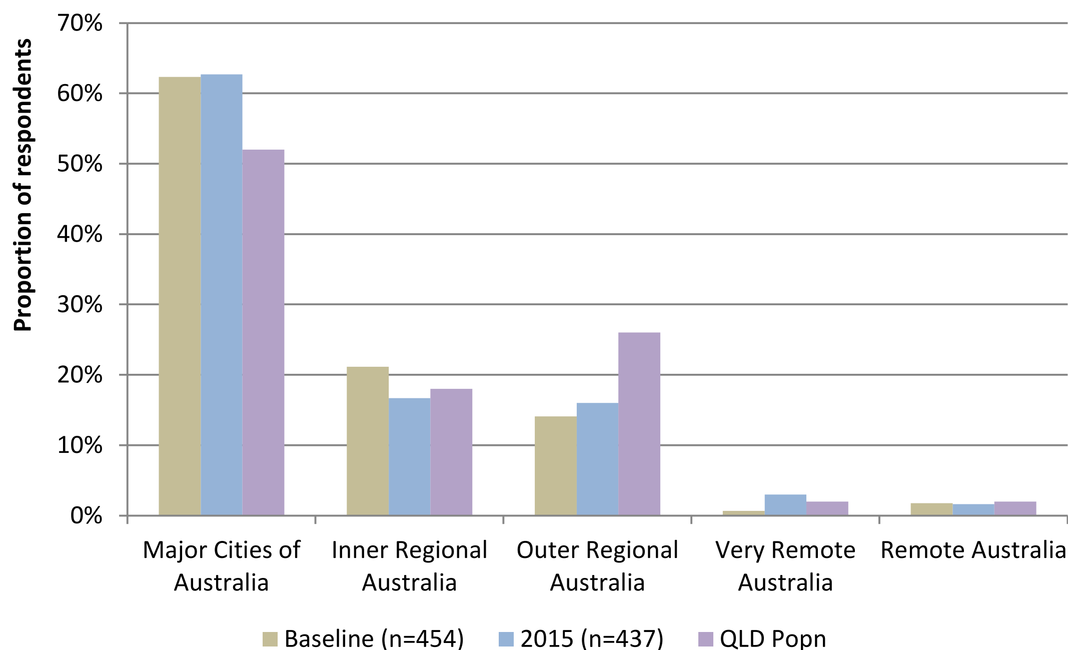
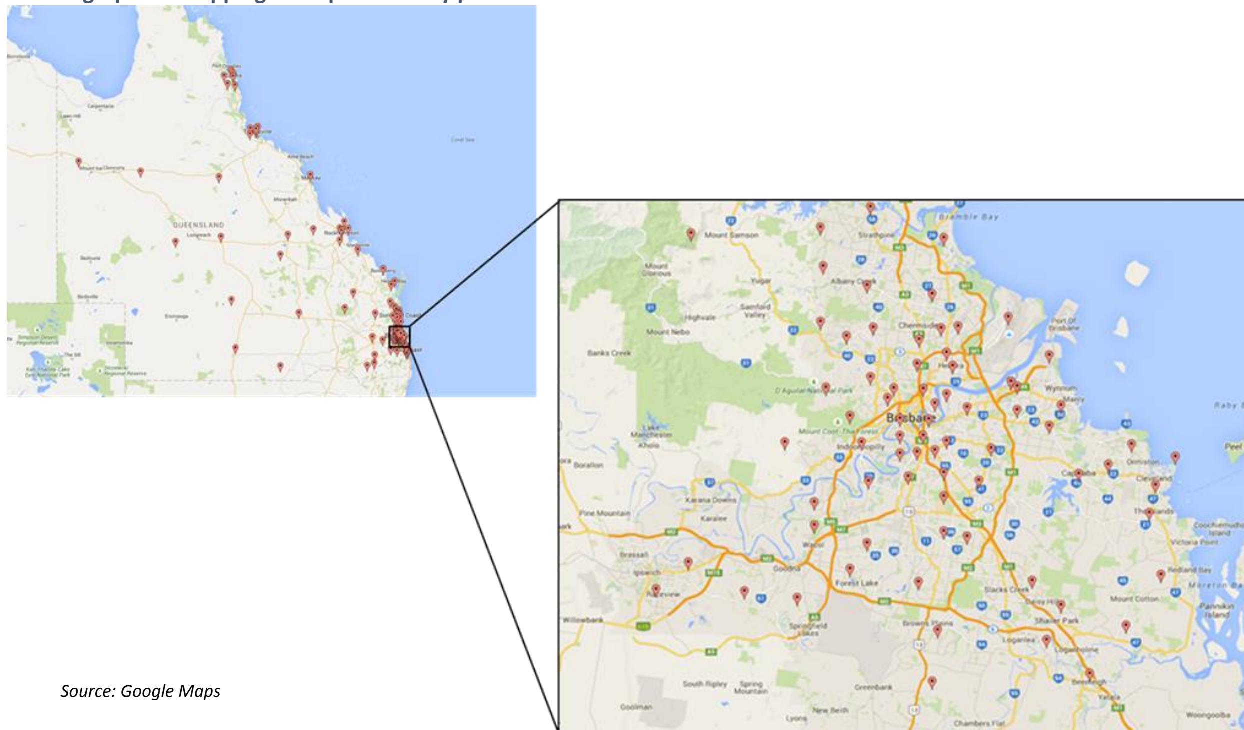


Figure 6 is a graphical map depicting the location of 2015 survey respondents by postcode. Unsurprisingly, the majority of respondents were clustered in Queensland, specifically around Brisbane. However, some respondents indicated their postcode as originating in New South Wales (NSW), Victoria and West Australia (WA).

Figure 6: Geographical mapping of respondents by postcode

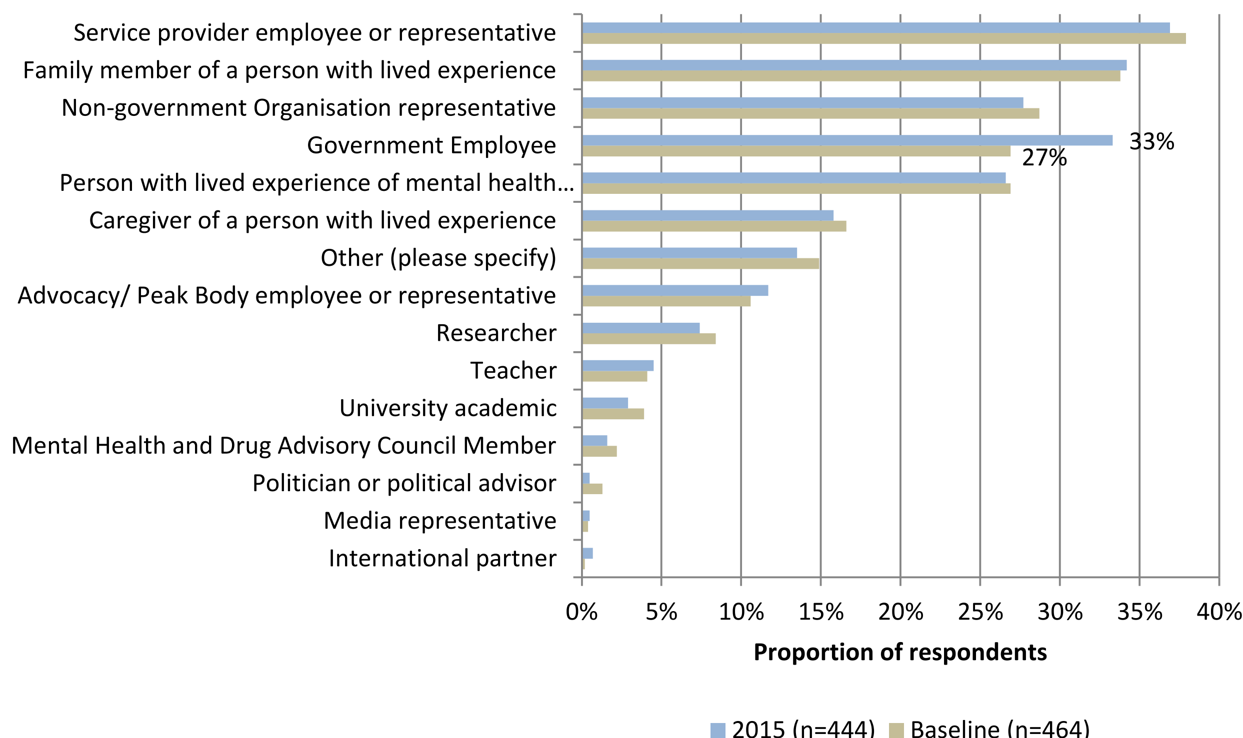


Source: Google Maps

Respondents represented a variety of roles in the community (Figure 7). 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. Just over a quarter of respondents to both the Baseline and the 2015 surveys were people with lived experience of mental health and/or substance misuse issues. The largest difference between the 2015 and Baseline surveys was an approximate 5% increase in the proportion of respondents identifying as government employees.

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

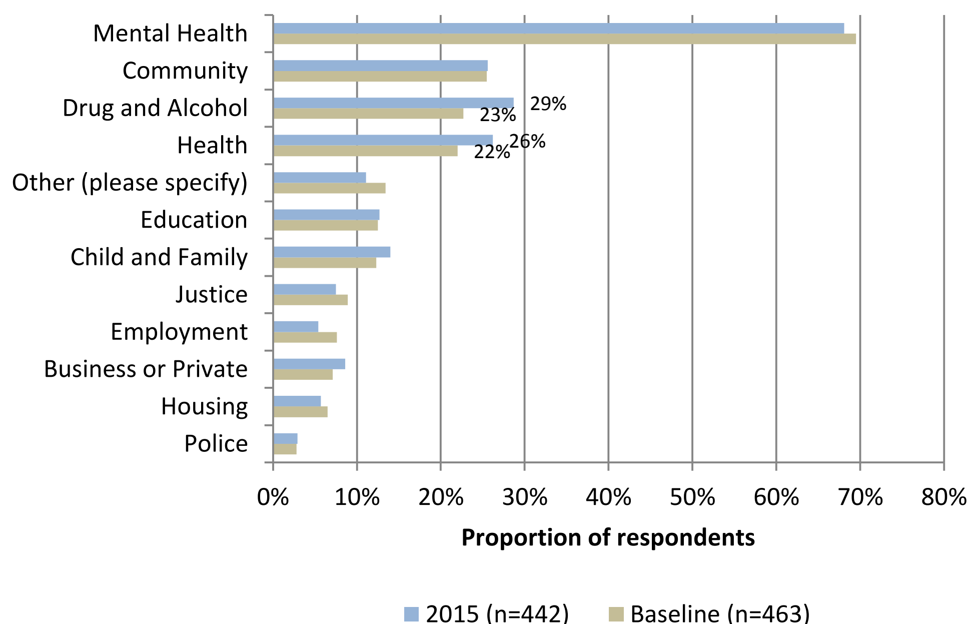
Figure 7: Role of survey respondents



Most sectors within Queensland were represented in the survey results (Figure 8), although the Mental Health sector dominated, comprising ~70% of the respondents. Compared to the baseline, there was a 6% and 4% greater proportion of the respondents identifying as being from the Drug and Alcohol and Health sectors, respectively. Less than 10% of respondents identified as representing Justice, Employment, Business or private, Housing or Police, suggesting a potential need for the QMHC to improve its engagement with these sectors given the intersection between these sectors and mental health.

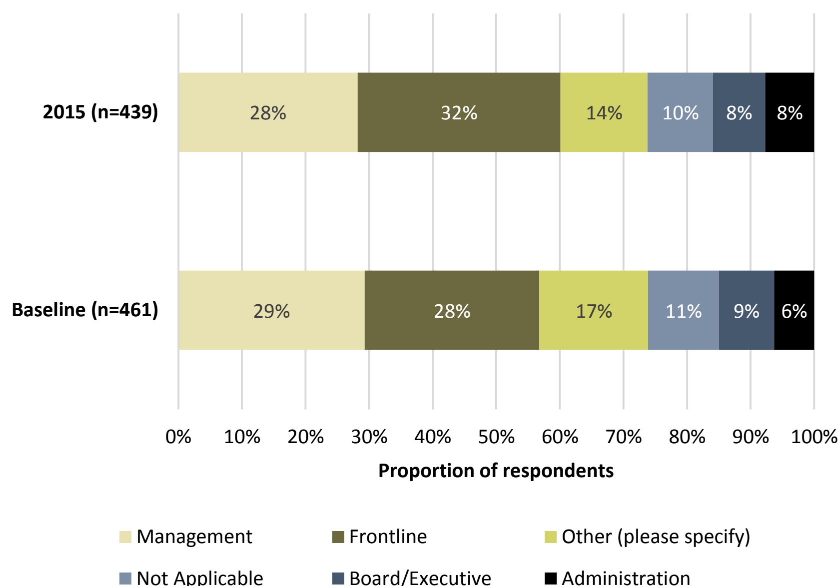
The 'Other' category was selected by 13% of respondents and contained a range of responses including Disability, Primary Healthcare, Youth, Aged Care and Indigenous.

Figure 8: Sectors represented by survey respondents



Additionally, as can be seen in Figure 9, 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. This also highlights that, in large part, the survey results represent the views of a broader range of stakeholders than just Board and Executives that were captured during the stakeholder consultations. Management and Frontline staff were represented in almost equivalent proportions. It is interesting to note is the slight increase in the percentage of frontline staff responding in 2015, relative to the Baseline survey (32% versus 28%), perhaps suggesting modest growth in awareness of the QMHC at service levels.

Figure 9: Positions of survey respondents



Over a quarter of all respondents to either the Baseline or 2015 survey identified as representing one or more priority populations.

Table 2 presents the proportion of overall survey respondents, at both Baseline and 2015, that identified with each priority population group, as compared to the indicative Queensland population rates.

Table 2: Survey respondents representing priority populations[7]

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

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

> *"There are weak links to Disability Services who support a significantly marginalised group who have dual diagnosis's"*
>
> *- 2015 Survey respondents*

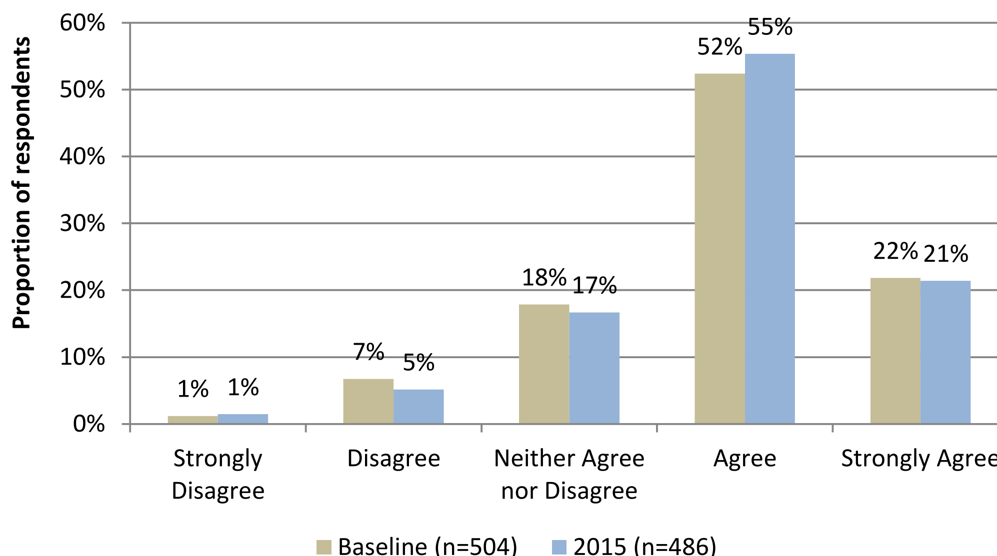
These results suggest that the proportion of survey respondents representing people with ATSI backgrounds was approximately double that of the proportion expected based on the QLD population. Conversely, people with CALD backgrounds and those with a disability were

[7] Groups were mutually exclusive – respondents could select more than one group.

considerably under-represented in both the Baseline and 2015 surveys, 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 10). Less than 10% of respondents, in both surveys disagreed. The remaining respondents neither agreed nor disagreed about their knowledge, suggesting they may be somewhat knowledgeable about the mental health, drug and alcohol system in QLD.

Figure 10: "*I feel knowledgeable about the mental health, drug and alcohol system in QLD*"



3.3.2 Targeted Review, Research and Reporting Mini Survey

As one of its Key Result Areas (KRAs), the QMHC undertakes and commissions research in relation to mental health and substance misuse issues and reviews, evaluates and reports on the mental health and substance misuse system. These Review, Research and Report (RRR) activities are aimed at informing decision-making related to existing activities and determining new initiatives.

Due to the important role of the RRR function, a targeted mini-survey was released to a limited group of stakeholders involved in the development of one or more initiatives where review and research work had reached at least one milestone in the form of a public report.

These initiatives included:

- Review on Social Housing
- Mental Health Act 2000 Review
- Least Restrictive Practices and Locked Wards
- Evaluation of the Ed-LinQ Program
- Perinatal and Infant Mental Health.

The survey, conducted in March 2015, was designed to support a focussed assessment of the QMHC's RRR activities.

Results from this survey are presented primarily in Section 4.4.2 of this report.

4. Evaluation results

This section describes the key findings from the evaluation activities to date against each of the evaluation domains. Each sub-section describes the key evaluation questions, the key evaluation findings and a series of recommendations (where appropriate). The findings are organised according to the Theory of Change, beginning with those areas within the QMHC's direct control, direct influence, and indirect influence leading to collective impact.

4.1 QMHC Organisational Enablers

Evaluation of QMHC Organisational Enablers

Does the organisational strategy align with the Queensland Mental Health Commission Act?	How are QMHC governance structure, systems and process supporting the organisational aims?	Is the internal resourcing appropriate for the organisational aims?	Does the internal culture provide alignment to the organisational strategy?

4.1.1 Key Findings

4.1.1.1 Does the organisational strategy align with the Queensland Mental Health Commission Act?

The foundation for development of the *QMHC Strategic Framework 2014-2018* ('the Strategic Framework') was the *Queensland Mental Health Commission Act 2013* ('the MH Commission Act'). The Strategic Framework articulates the overarching Vision for the QMHC, its purpose, the outcomes it intends to achieve and the strategies (Key Result Areas) it plans to implement to achieve them.

4.1.1.2 How are the QMHC governance structure, systems and process supporting the organisational aims?

The QMHC has one chief executive position (the Commissioner). However, the Queensland Mental Health and Drug Advisory Council (MHDAC) also has a role to support the Commissioner in providing independent advice on specific issues and assisting in disseminating the outcomes of QMHC activities to respective networks.

Through the stakeholder consultations, the 2015 survey, and discussions with the QMHC executive team an opportunity was identified to strengthen the governance of the QMHC on two key fronts. Firstly, it was suggested that, like the NSW Mental Health Commission and the National Mental Health Commission, the QMHC may benefit from having multiple Deputy Commissioners to 'spread the load' and add an additional breadth of input into decision making.

Secondly, as previously identified during the Baseline, some stakeholders expressed that the composition of the MHDAC could be revisited to strengthen representation from rural and remote areas and CALD communities. The perception that the views of CALD groups are under-represented in the QMHC's work was identified in the Baseline report and the most recent results suggest that more may need to be done in this area.

There may also be a broader opportunity to improve the transparency of the processes around how MHDAC members are selected, the group's role and how it influences the QMHC's work.

In the 2014/15 period, the Commission also convened two new advisory committees to strengthen overall governance and provide ongoing input into the Commission's activities:

- The **Consumer, Family and Carer Committee**: focuses on projects to influence consumer, family and carer engagement in system reform with a range of initiatives on track for delivery in 2015.

- The **Aboriginal and Torres Strait Islander Committee**: provides advice on initiatives that require the input of Aboriginal and Torres Strait Islander communities.

4.1.1.3 Is the internal resourcing appropriate for the organisational aims?

Consultation with the QMHC executive team and other stakeholders identified that early in the QMHC's establishment the Commission's human resources may have been both insufficient in number and narrow in skill base to enable it to meet its legislative obligations.

More recently, these aspects have improved with the approved staffing establishment increased from 10 to 15 FTE including the recruitment of a senior executive officer with interagency experience. Other specific examples:

- **Communications and Engagement**: Communications and Engagement is a critical function of the QMHC. Towards the end of 2014, there was a restructuring of the QMHC team, and a Senior Communications Officer was appointed, along with an AO5 level support role focused on the website and communications. In addition, to further support these new internal resources, the QMHC has invested in expert external advice to support improved promotion and media releases and expanded its existing website contract to include a QMHC intranet and a refresh of the QMHC website across the 2015/16 year.

  With the additional depth in this function, there has been a marked improvement in the website layout and copy, consistency in the 'look and feel' of QMHC publications, the launching of the QMHC Facebook page and an increase in the number of QMHC media releases.

- **Resources able to translate the evidence base around mental health and substance misuse issues into policy positions for the QMHC:** The QMHC is expected to understand and utilise the best available evidence regarding mental health and substance misuse issues to influence policy development and decision-making at the local, system and government levels. This requires personnel that have a broad understanding of, and appreciation for, the prevailing government environment, the mechanics of government, and that can translate evidence into meaningful information and knowledge that can inform decisions, communication and policy development. These personnel must also develop and maintain relationships within government and the non-government sector to facilitate negotiation on specific issues as required. In 2014, stakeholders identified that QMHC resources fulfilling these requirements were limited.

  The restructure of the QMHC's resources in late 2014 introduced three teams focused around the KRAs and more broadly strategic planning. While not empirically tested, anecdotally, this appears to have added additional depth of capacity and co-ordination around how issues are responded to.

  Where further specialist resourcing has been required the QMHC has also engaged the required expertise on an 'as required' basis. Examples of this include engagement of a part-time consultant psychiatrist, and consultants with lived experience of mental illness and of suicide.

4.1.1.4 Does the internal culture provide alignment to the organisation strategy?

In parallel with the more recent improvements highlighted above, the Commission has engaged its staff in a number of 'all-staff' planning meetings in which the team jointly articulated the values and behaviours that they see as important to foster within the organisation.

In early 2015, the Commission undertook an 'Organisational Climate Review' that included one-on-one interviews with all staff around the following domains:

- Agency Engagement
- Job Engagement
- Job Empowerment
- Role Clarity

- Organisational Trust
- Performance Assessment
- Workplace Fairness
- Workplace Health & Safety
- Discrimination
- Decision Making
- Collaboration
- Learning & Development
- My Manager
- My Workgroup
- Workplace Change

These individual discussions were followed up with a group discussion involving all staff, to identify necessary actions and any areas of particular concern. The result of this process was the development of an action plan to address the key areas of concern. The Action Plan identified a series of key objectives, each accompanied by a series of specific actions (not shown).

The Commission has committed to conducting an annual organisational climate review each February that includes a review of the actions undertaken and a comparative assessment with the previous year(s) results.

As 2014 was the first year of the review, no comparative results were available. However, anecdotally, there has been an improvement in staff understanding and appreciation for the QMHC's Vison, individual staff roles, and how staff contribute to achieving the QMHC's strategic objectives.

4.1.2 Summary

A review of the QMHC Strategic Framework suggests that it is firmly grounded in, and based on, the requirements of the Act. Therefore, it is an appropriate framework against which to develop more detailed operational plans and to prioritise activities within those plans.

It appears that the internal resourcing of the Commission has improved significantly over the last year in terms of composition, structure and focus and, while only anecdotal, this appears to have translated into more effective initiatives and improved internal co-ordination. However, stakeholders saw an opportunity to strengthen the capacity and governance of the Commission further through the introduction of additional deputy Commissioner/s, as seen in other Mental Health Commissions (e.g. NSW, National). The Commission is conscious of the importance of organisational culture to its effectiveness and has invested in a structure to monitor and improve this core aspect of its operations.

4.1.3 Recommendations

Recommendation 1: The Commission should work with the Government to consider strengthening governance through the inclusion of a Deputy Commissioner (or multiple Deputy Commissioners focusing on specific areas).

Recommendation 2: When the MHDAC membership is renewed, consideration should be given to ensure appropriate representation of the needs of CALD communities

Recommendation 3: The Commission should continue to monitor and actively manage its own organisational culture.

4.2 QMHC Partnerships

Evaluation of QMHC Partnerships

How well has the Commission facilitated the building of effective cross/whole of government collaborations?

How well has the Commission facilitated the building of effective collaborations within specific departments and organisations?

How well has the Commission built effective collaborations with government and other bodies toward addressing common goals and issues?

How well has the Commission facilitated the building of effective collaborations between service delivery partners?

4.2.1 Key findings

4.2.1.1 How well has the Commission facilitated the building of effective cross/whole of government collaborations?

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.

In the 2014/15 period, the Commission worked to strengthen its partnerships with various Government departments through working together on specific initiatives such as:

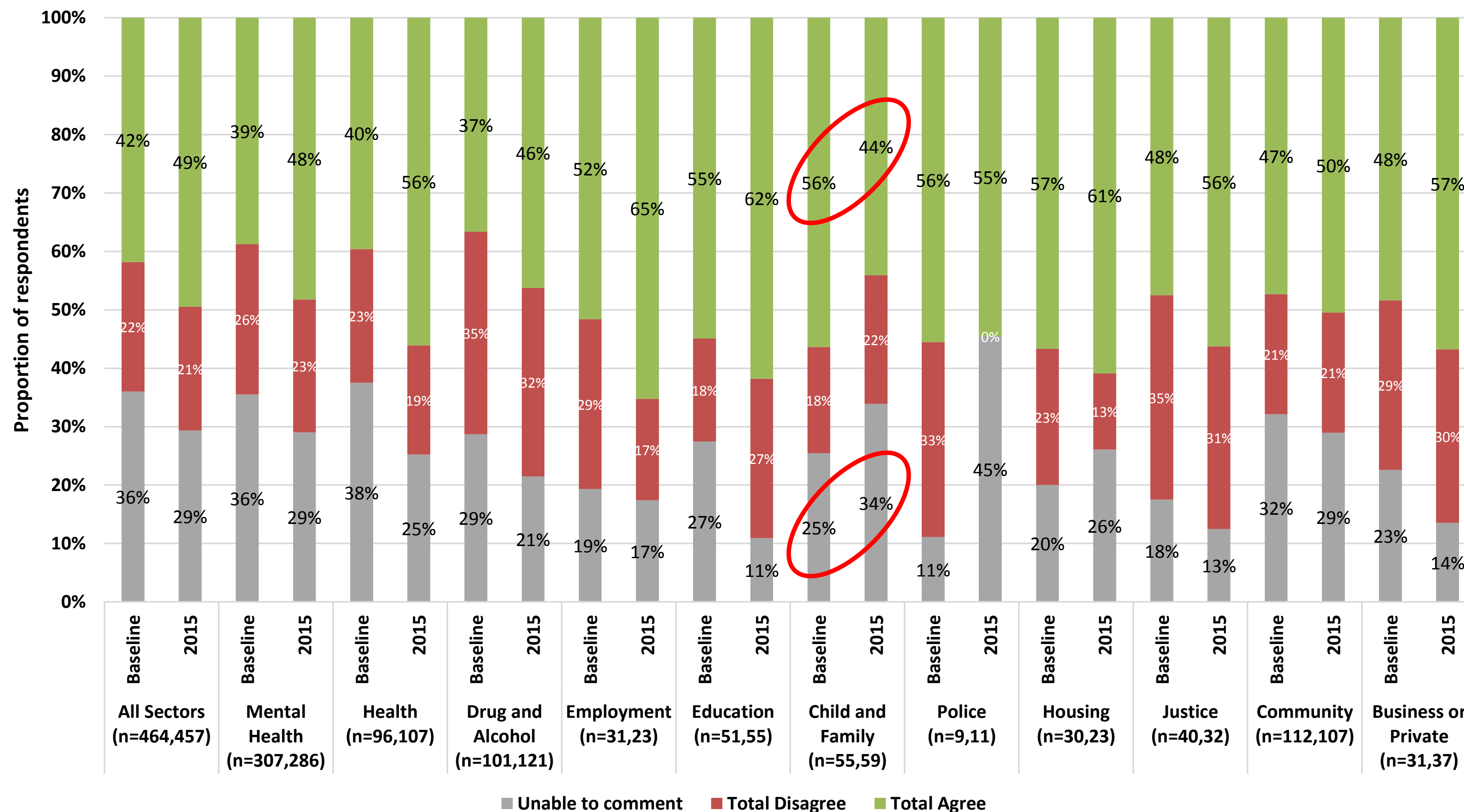
- Review of the *Mental Health Act 2000* (with Queensland Health)
- Development of action plans for suicide prevention, early intervention and drugs and alcohol
- Provision of advice on the Mental Health Drug and Alcohol Service Plan (with Queensland Health)
- Review of Social Housing (with Department of Housing and Public Works)
- Review of options for improved police interaction with people with a mental illness (with Queensland Health and Queensland Police Service).

While most of these joint initiatives are still in development and have not been evaluated at this point, on face value, the explicit focus on working with other departments on specific initiatives suggests that the Commission has made progress towards building working relationships with a number of key Government Departments.

This observation is further supported by the fact that a greater proportion of respondents to the 2015 survey (compared to Baseline) agreed that the QMHC is helping to improve collaboration across sectors (Figure 11). This was true at the overall (7% greater) aswell as for respondents from almost all sectors tested. The largest improvements observed were for the sectors of Health (16%), Employment (13%), and Mental Health, Drug and Alcohol and Business/Private (all 9% greater).

The single exception was for survey respondents from the Child and Family sector, for which there was a decline of 12% (between the Baseline and 2015 Surveys) in the proportion agreeing that the QMHC is helping to improve collaboration across sectors. Interestingly, there was an approximately equivalent increase in the proportion of this group indicating being unable to comment. This may suggest that the 2015 survey respondents from this sector were less confident to comment on the question.

Figure 11: *"The QMHC is helping to improve collaboration across sectors (e.g. between health and justice, education, community, etc.)"*



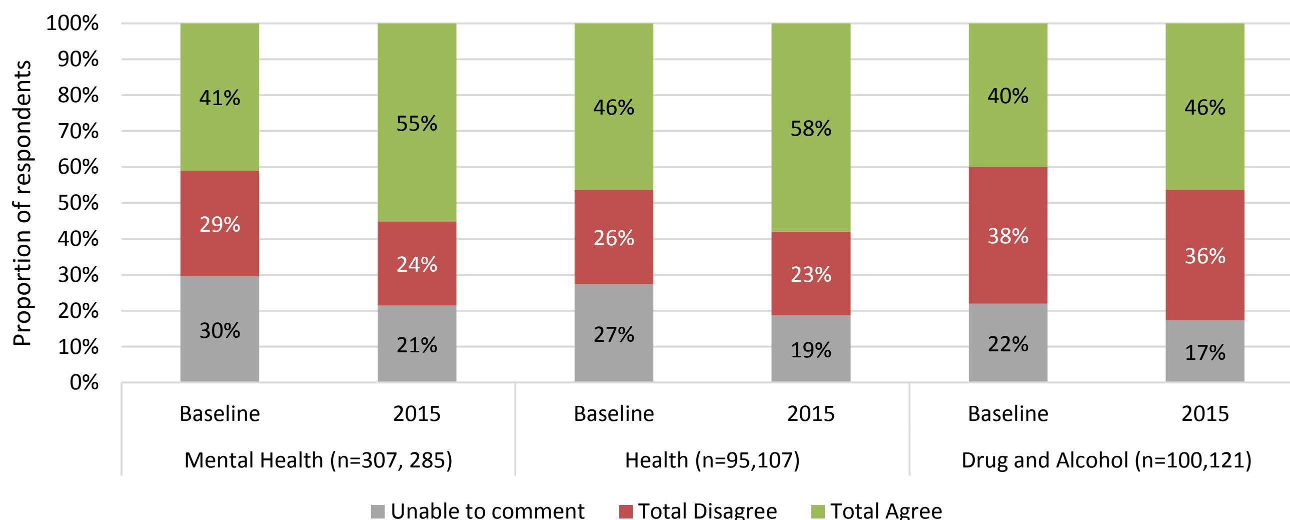
n= (# Baseline respondents, # 2015 respondents)

Overall, these results suggest the Commission has made reasonable progress over the last year in strengthening partnerships with and between other sectors and has made important contributions to the progress of important initiatives in other governmental areas.

4.2.1.2 How well has the Commission facilitated the building of effective collaborations within specific departments and organisations?

While collaborations within specific departments or organisations were not tested in Stage 2 of the evaluation, the annual survey did provide some insight into the perceptions of improved collaboration within the mental health, drug and alcohol sectors. Compared to the Baseline survey, greater proportions of 2015 survey respondents representing the Mental Health (14%), Health (12%) or Drug and Alcohol (6%) sectors agreed that the QMHC is helping to improve collaboration within the mental health, drug and alcohol sectors.

Figure 12: "*The QMHC is helping to improve collaboration within the mental health, drug and alcohol sectors*"



4.2.1.3 How well has the Commission built effective collaborations with government and other bodies toward addressing common goals and issues?

The Commission worked in partnership with various government departments, providing expertise, leadership and support, toward addressing the common goals specific to individual initiatives (see Section 4.2.1.1).

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.

To this end, in the 2014/15 period, the Commission has:

- Entered into a formal partnership (MOUs) between the Australian National Mental Health Commission and the New Zealand Mental Health Commissioner
- Maintained its partnership with Queensland Health through regular and targeted meetings with the Deputy Director General, the Director Mental Health and the Chief Psychiatrist.
- Worked with the Chair of the Hospital and Health Board Chairs and the Mental Health, Alcohol and Other Drugs and Maternity and Neonatal Clinical Networks
- Worked with Queensland Network of Alcohol and other Drug Agencies (QNADA) to commence development of an Alcohol and Other Drug Action Plan
- Established and maintained partnerships with the following additional organisations that support and add value to the functions of the Commission:
    - Queensland Aboriginal and Islander Health Council (QAIHC)
    - Queensland Voice

- Queensland Alliance

It is too early to comment on the impact of these new arrangements. However, further work in developing meaningful and effective partnerships with key stakeholders is identified in the QMHC Operational Plan 2015/16. This is a critical enabler and area of Direct Influence in the Theory of Change and is seen as critical to supporting longer term Collective Impact.

4.2.1.4 How well has the Commission facilitated the building of effective collaborations between service delivery partners?

As noted above, without effective collaboration between service delivery partners, it will not be possible to achieve the objectives of the Strategic Plan and larger scale impact. This is the area where change may take the longest due to the time required to translate changes at the policy and strategy level into different ways to deliver services (See Figure 2: Theory of Change).

To facilitate improved engagement between the Commission and clinical MH services (an area identified as lacking through the direct stakeholder consultations), the Commission has appointed a part-time Consultant Psychiatrist to:

- Provide appropriate clinical advice to the Commission as requested
- Represent and promote the QMHC in strategic clinical settings at state and national levels.

This appointment should assist in fostering collaboration at the service provider level, at least within the Health sector. However, effective collaboration must also be facilitated between service providers from different sectors to support improved integration of the service system and effective and seamless transitions for consumers, between different sectors.

4.2.2 Summary

During the 2014/15 period, the Commission undertook a number of key initiatives with various Government Departments, and established and maintained working partnerships with a number of peak bodies and agencies. This coincided with an increase in the proportion of survey respondents agreeing that the Commission is helping to improve collaboration both between sectors and within the mental health, drug and alcohol sectors.

Table 3 (adapted from Himmelmann[8]) outlines the progressive stages of maturity of collaboration. 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.

While difficult to assess empirically, and not investigated explicitly in this stage of the evaluation, the evaluation findings suggest that the Commission has primarily achieved the stage of "co-ordinating" with most of its targeted partners (red box). Some initiatives such as the Development of an action plan for rural and remote priorities (with Queensland Health and Department of Communities, Child Safety and Disability) move the work further on the continuum to that of co-operating.

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

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 the Commission appears to have strengthened its own partnerships with stakeholders across multiple sectors, as it matures further it must now also assist in fostering independent networks and collaborations between multiple departments and organisations to ensure ongoing sustainability. This aligns to one of the key attributes of effective 'Backbone Organisations' (see Section 2.2.1.1) that is to be 'selfless'– honest brokers with no personal stake[9]. This is another effort that will be critical to achieving longer-term impacts that are outside of the direct influence of the Commission and required to achieve collective impact.

Another reason for fostering such collaborations is to ensure that any new partnerships are not just limited to specific initiatives, but rather the principles of collaboration become embedded in how the organisations operate together to jointly address MH and AOD issues. As described in Section 5, it is intended that a targeted assessment of the strength of the QMHC's partnerships will be undertaken employing a more structured assessment approach (potentially including a partnership assessment or network analysis tool).

4.2.3 Recommendations

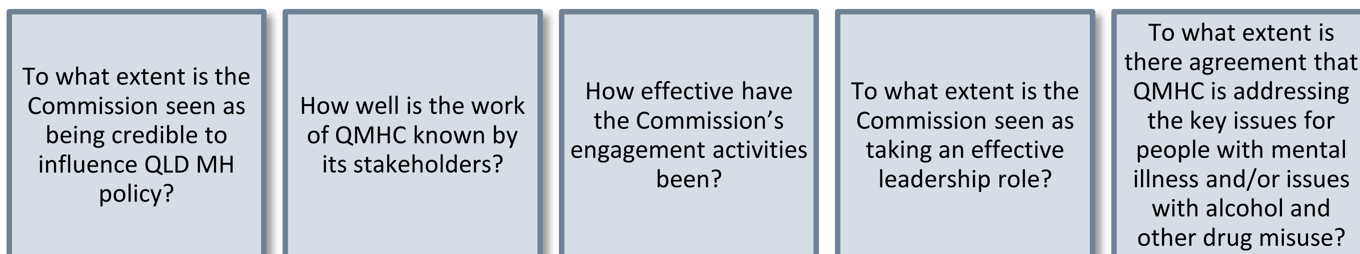
Recommendation 4: The Commissioner should work with government departments to convene, and engage periodically, a cross-governmental committee (e.g. housing, justice, communities child and family, education, employment) (Directors General) to facilitate discussion on the delivery and ownership of activities under the Strategic Plan.

Recommendation 5: The Commission should prioritise the establishment of formal partnerships and complementary work with groups representing CALD communities in Queensland.

Recommendation 6: The Commission should identify tangible initiatives around which to foster the building of effective communities of practice that include service providers from different sectors to identify, and jointly design solutions to, the key service delivery issues facing their respective service users.

[9] Turner, S., Errecart, K., & A. Bhatt, A., (2013). Measuring backbone contributions to collective impact." *Stanford Social Innovation Review*. http://www.ssireview.org/blog/entry/measuring_backbone_contributions_to_collective_impact

4.3 QMHC Profile

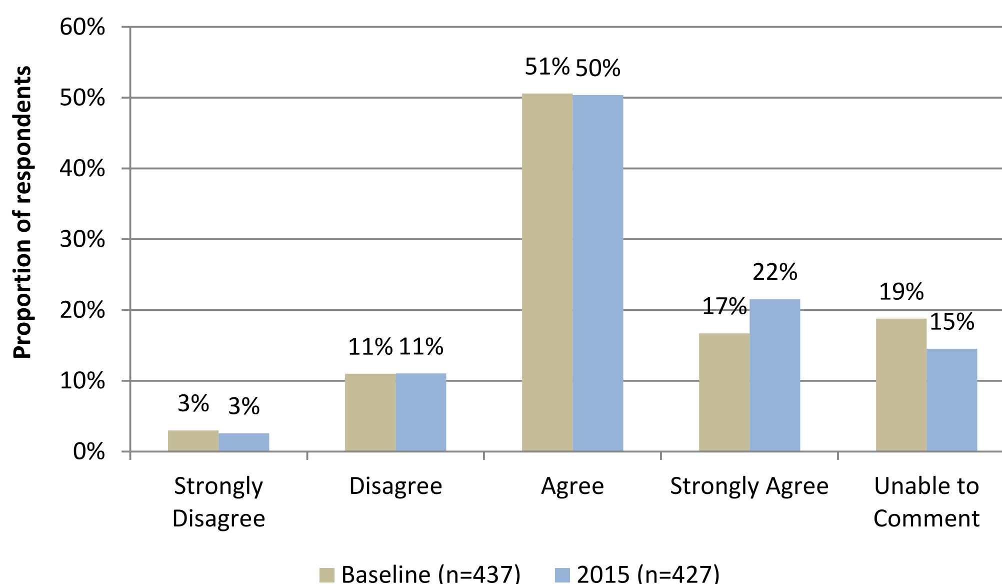


4.3.1 Key Findings

4.3.1.1 To what extent is the Commission seen as being credible to influence QLD MH policy?

About half of respondents to both the Baseline and 2015 surveys agreed that the QMHC is seen as a credible organisation (Figure 13). Encouragingly, an additional 22% of respondents to this question in the 2015 survey (an additional 5% compared to the Baseline), strongly agreed that the QMHC is seen as a credible organisation indicating that 72% of 2015 respondents agree that the QMHC is seen as credible. There was an approximately commensurate decrease in the proportion of 2015 respondents to this question that indicated being unable to comment.

Figure 13: ***"I believe the QMHC is seen as a credible organisation"***

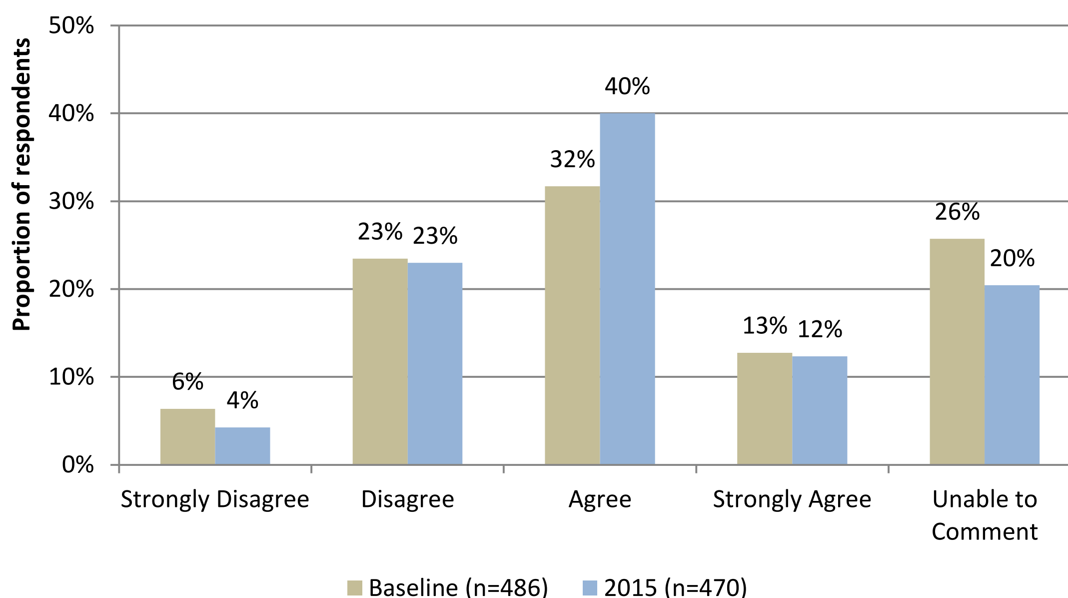


Supporting these results, were the stakeholder consultations. The perceived independence of the QMHC was seen as a key contributor to its credibility. In fact, the survey revealed that the total proportion of people indicating that they agree the QMHC is operating independently of Government increased between the baseline and the 2015 survey (Figure 14). There was an approximately equivalent decrease in the proportion of respondents that indicated being unable to comment.

> *"[the Commission is] Open and transparent…..an independent voice outside of bureaucratic processes and silos"*
>
> - *2015 Survey respondent*

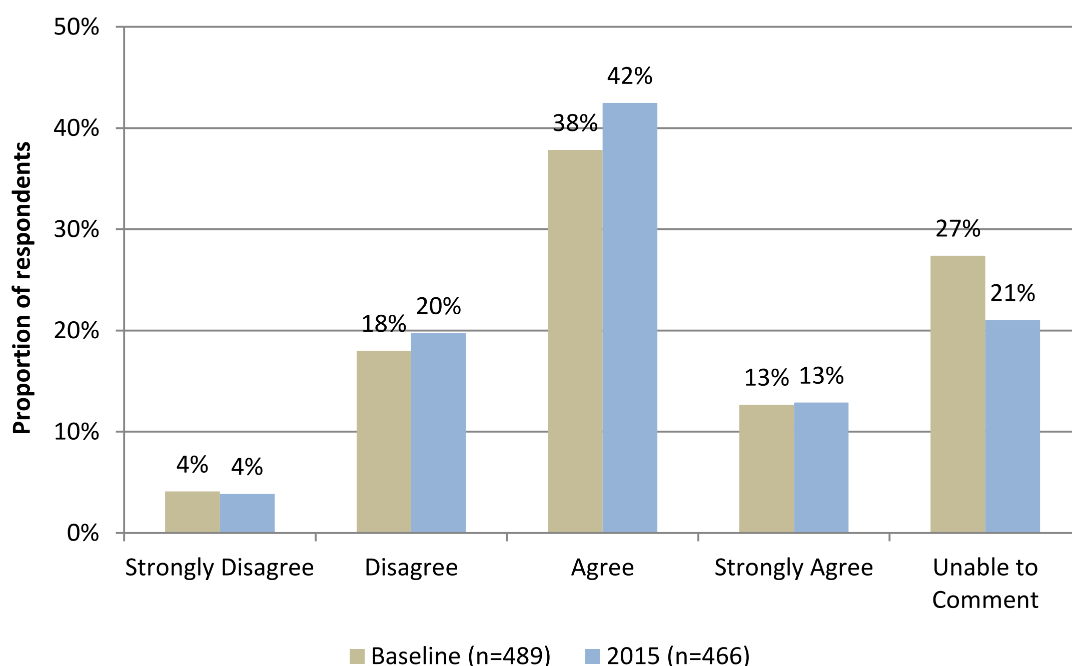
This may suggest that there is not only an improved perception amongst stakeholders of the QMHC's independence from Government, but also an increase in the number of respondents who feel informed enough to provide feedback.

Figure 14: ***"The QMHC is operating independently of Government"***



Similarly, a 4% greater proportion of 2015 respondents (as compared to Baseline) agreed the QMHC is operating independently of Queensland Health and other government agencies (to a total of proportion of 55% of respondents). There was an approximately equivalent decrease in the proportion of respondents that indicated being unable to comment. However, this proportion remained high at approximately one-fifth of respondents.

Figure 15: ***"The QMHC is operating independently of Queensland Health and other government agencies"***



These results were consistent with stakeholder feedback during the follow-up consultations, the majority of which suggested that the QMHC is operating independently. Notably, the Commission's recent reports were cited as a display of the Commission's independence and role in challenging and contributing to the debate on specific issues. However, a minority of stakeholders disagreed that the QMHC is operating independently and its 'structural' linkage to Queensland Health was cited as compromising its ability to ever be "truly" independent. This will be an interesting perception to monitor as the QMHC, while maintaining independence, must work collaboratively with other agencies to fulfil its mandate, support the work of other agencies, and collaborate.

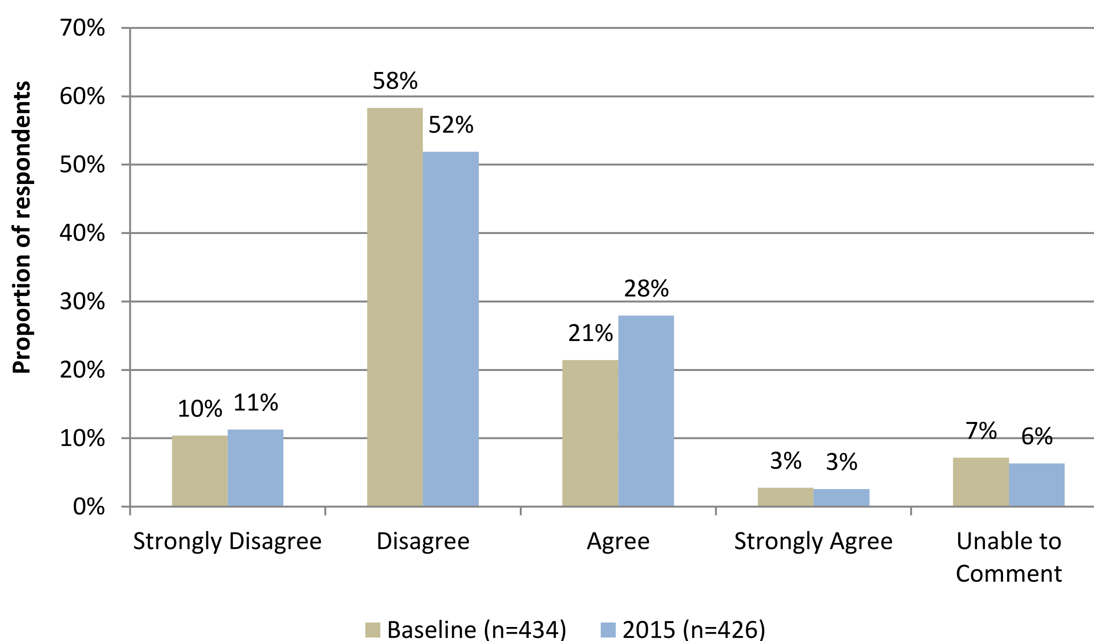
4.3.1.2 How well is the work of the QMHC known by its stakeholders?

Figure 16 shows that a total of only 24% and 31% of Baseline and 2015 survey respondents, respectively, agreed that there is a high level of awareness of the QMHC. This question had the lowest level of agreement of all questions in both the Baseline and 2015 surveys. While there was an improvement between the Baseline and 2015 survey, this suggests that a significant opportunity still exists for the QMHC to increase its profile.

Of those that provided a response to the question, approximately 93% provided a valid response (i.e. did not indicate "Unable to comment"). This suggests that almost all respondents in both surveys were confident to provide an answer to this question – increasing the validity of the result.

> *"Hear very little of the work and actions being done by the QMHC. This is a slow process of reform through key stakeholders time is needed to see results. Perhaps some frustration from stakeholders to see changes sooner"*
>
> - *2015 Survey respondent*

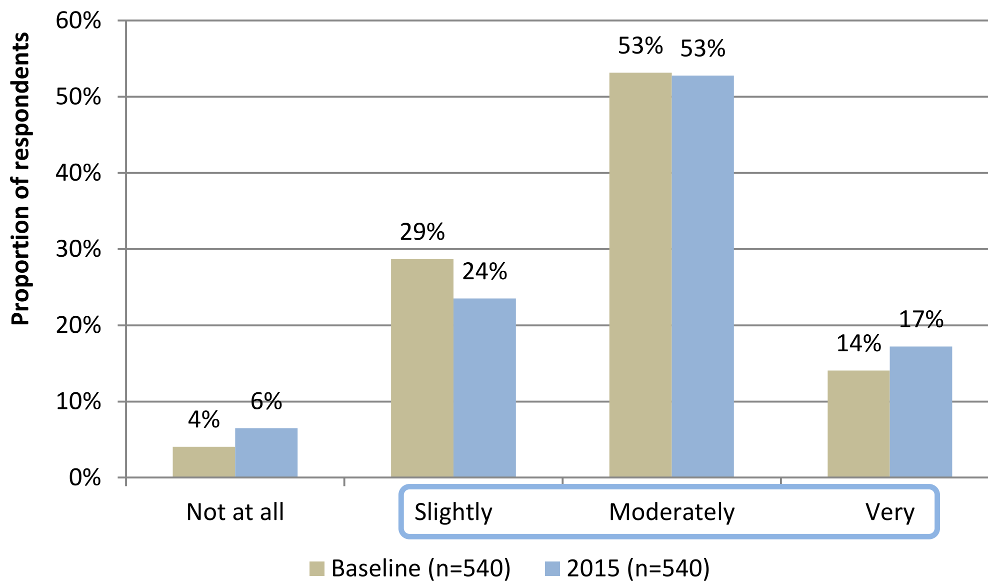
Figure 16: ***"I believe there is a high level of awareness of the QMHC"***



Somewhat contradictory to this result, the majority of respondents indicated that they were at least moderately familiar with the QMHC and the work that it does, with a small increase (compared to the Baseline) in the proportion of 2015 survey respondents indicating that they felt 'very' familiar (Figure 17).

Taken together, these results may suggest that while survey respondents themselves felt familiar with the Commission's work, they were not confident that there was a high degree of awareness more broadly across the mental health and drug and alcohol sectors. As the Commission continues to engage in work involving partners in key initiatives there should be growth in broader awareness.

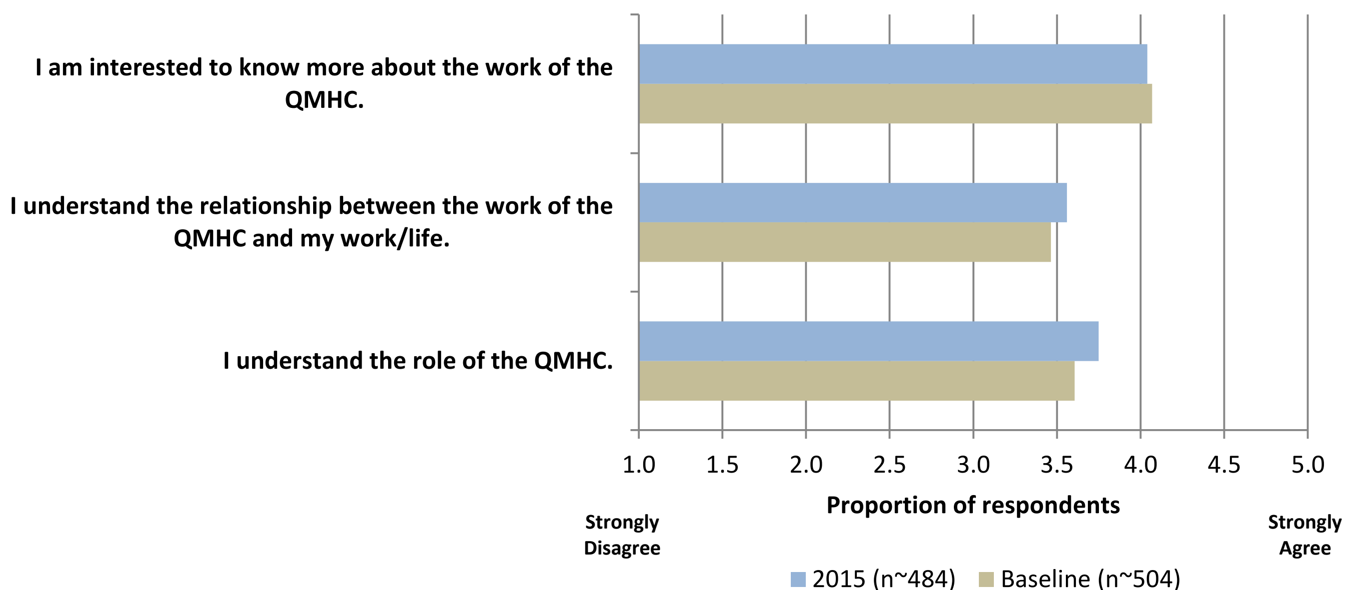
Figure 17: *"To what degree are you familiar with the QMHC and the work that it does?"*



Those respondents indicating being at least 'slightly' familiar with the QMHC and the work that it does (blue box) answered a series of additional questions regarding their understanding of the QMHC (Figure 18).

The majority of these respondents indicated that they were interested to know more about the work of the QMHC, whereas the lowest agreement for this group of questions was regarding respondents' understanding of the relationship between the QMHC and their work/life; with a weighted average score closer to the neutral response of Neither Agree nor Disagree (3.0).

Figure 18: Understanding of the QMHC



4.3.1.3 How effective have the Commission's engagement activities been?

The Commission engages with stakeholders through a variety of modes, both in person and via electronic and paper-based means. Notably, in early 2015 the Commission launched a dedicated Facebook page. Albeit still in its relative infancy, this mode has been highly successful to date in promoting the QMHC's activities and engaging with a new audience and has close to 500 'likes' already.

> *"Newsletter and email is very strategic and comprehensive"*
>
> - *2015 Survey respondent*

The largest proportion of survey respondents indicated that they had interacted with the QMHC via mail or email (close to 70% in both the Baseline and 2015 surveys). Encouragingly, compared to the Baseline survey, for all other listed modes of engagement there was an increase in the proportion of respondents indicating that they had interacted with the QMHC via the specific mode.

The largest single increase was in the proportion of respondents indicating "QMHC reports" as a form of contact (9% between the Baseline and 2015 surveys). This may be expected as, in the last year, the QMHC has been active with leading, contributing to, and releasing a number of formal reports (see Section 4.4.2). The increase in the contact via website is also worth noting.

Figure 19: Modes of interaction with the QMHC

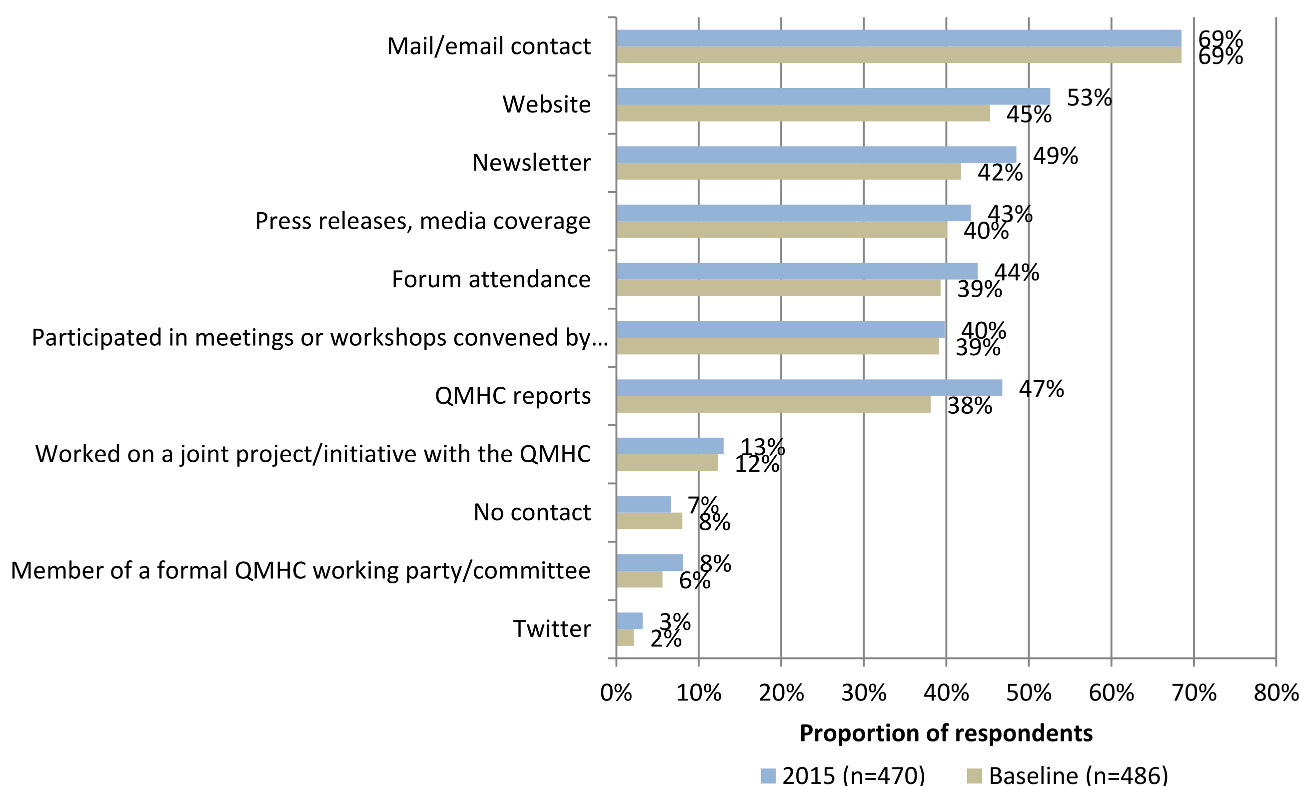


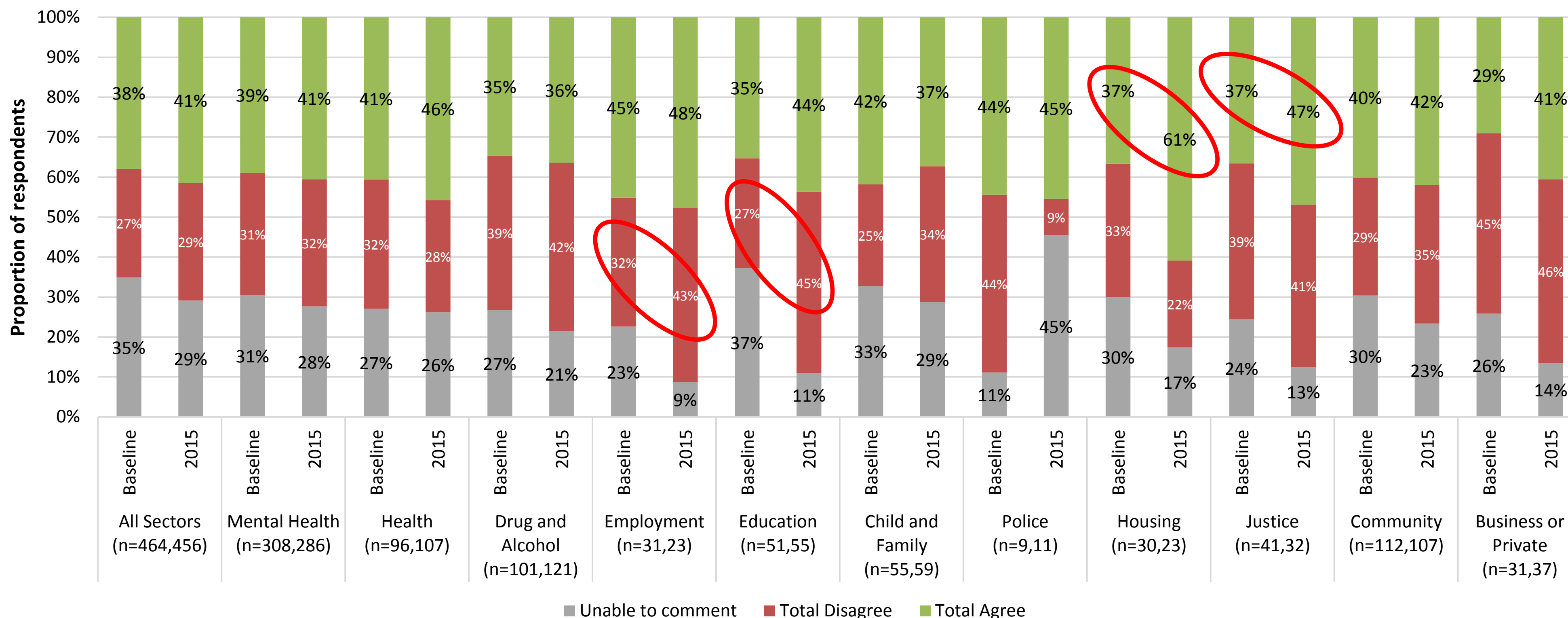
Figure 20 profiles the extent of agreement across various sectors with respect to whether the QMHC is engaging the full range of relevant stakeholders. At an overall level, there was marginal change, between the Baseline and 2015 surveys, in the proportion of respondents agreeing (~40%) or disagreeing (~30%) that the QMHC is engaging the full range of relevant stakeholders. The remaining respondents indicated being unable to comment.

However, there were some notable changes between the Baseline and 2015 surveys for specific sectors. This included 11% and 18% greater proportions of respondents representing the "employment" and "education" sectors, respectively, disagreeing that the QMHC is engaging the full range of stakeholders. Conversely, 24% and 10% greater proportions of respondents representing "housing" and "justice", respectively, agreed that the QMHC is engaging the full range of stakeholders.

With the exception of "housing" in the 2015 survey, in no case did greater than half of respondents representing a particular sector agree that the QMHC is engaging the full range of relevant stakeholders. This suggests that, while the QMHC is engaging with the breadth of sectors, there is a need to engage more deeply within each sector. The Commission has identified this area as a focus for 2015/2016[10].

[10] Personal communication with QMHC

Figure 20: *"The QMHC is engaging the full range of relevant stakeholders"* – by sector



n= (# Baseline respondents, # 2015 respondents)

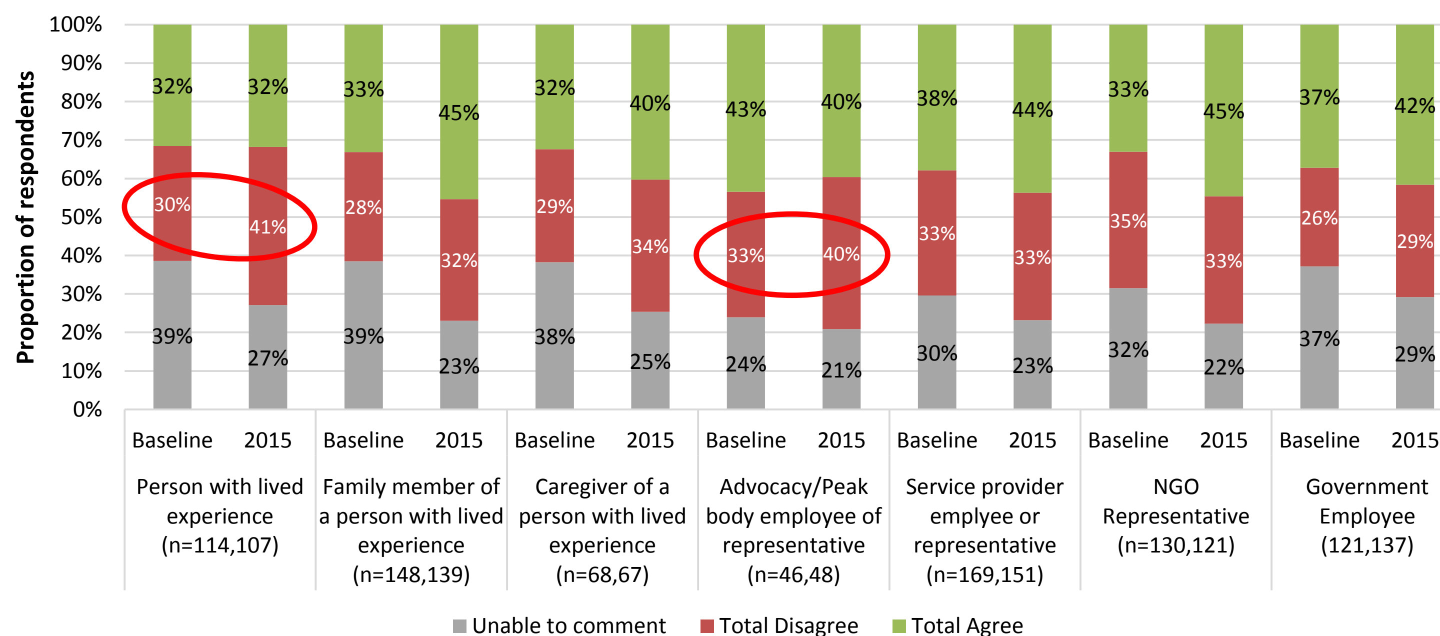
Figure 21 profiles the extent of agreement across various respondent groups with respect to whether the QMHC is engaging the full range of relevant stakeholders. In most cases, there was an increase in the proportion of respondents agreeing that the QMHC is engaging the full range of stakeholders, between the Baseline and 2015 surveys. For example, 12% more family members of persons with a lived experience agreed that the QMHC is engaging the full range of stakeholders in the 2015 survey, compared to the Baseline. Similarly, a 12% greater proportion of NGO representatives responded in the positive in the 2015 survey.

Conversely, more people with lived experience disagreed that the QMHC is engaging the full range of stakeholders between the Baseline and the 2015 survey. Notably, in this instance the proportion that agreed remained constant at 32%, while the proportion indicating being unable to comment declined by an approximately equivalent amount (12%). This may suggest, paradoxically, that a greater proportion of people with lived experience felt informed enough to comment but disagreed that the QMHC is engaging the full range of relevant stakeholders.

This result was somewhat surprising as, in addition to its ongoing focus on the inclusion of consumers, carers and families in their work, the QMHC undertook a number of activities in the 2014/15 year targeted specifically at improving consumer, family and carer (CFC) engagement. These activities included convening the Consumer, Families and Carers Committee, contracting the mapping of consumer, family, carer engagement in the public, private and NGO sectors and the contracting of the development of a set of bets practice principles for CFC engagement.

Interestingly, in the 2015 survey (compared to the Baseline) there were 12% and 8% higher proportions of family members and caregivers, respectively, of people with lived experience that agreed the QMHC is engaging the full range of relevant stakeholders suggesting that these groups had a more favourable view of the Commission's engagement activities than did people with lived experience.

Figure 21: *"The QMHC is engaging the full range of relevant stakeholders"* – by respondent role

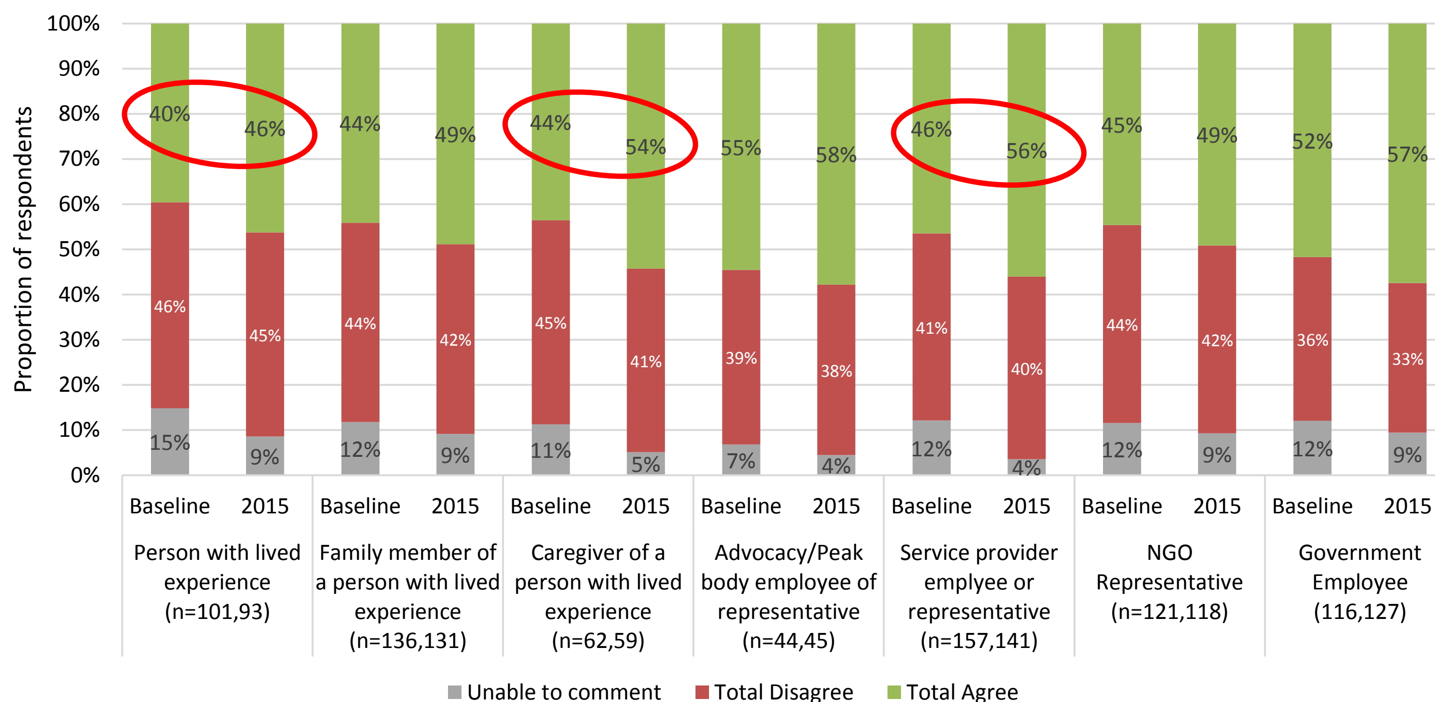


n= (# Baseline respondents, # 2015 respondents)

Somewhat contradicting the result in Figure 21, Figure 22 shows a 6% greater proportion of 2015 survey respondents with lived experience agreeing that they had sufficient opportunities to provide input into the work of the QMHC. Similar to the discrepancy observed between Figure 16 and Figure 17, taken together these results may suggest that in general survey respondents with lived experience are less convinced that the QMHC is engaging the full range of stakeholders, but that they themselves have had sufficient opportunity to input into the work of the QMHC.

All other respondent roles indicated at least similar improvements (3%-5%) between the Baseline and 2015 surveys, with caregivers of people with lived experience and service providers indicating the greatest improvements (10% greater proportion agreeing that they had had sufficient opportunity to provide input into the work of the QMHC).

Figure 22: ***"I have had sufficient opportunities to provide input into the work of the QMHC"*** **– by respondent role**



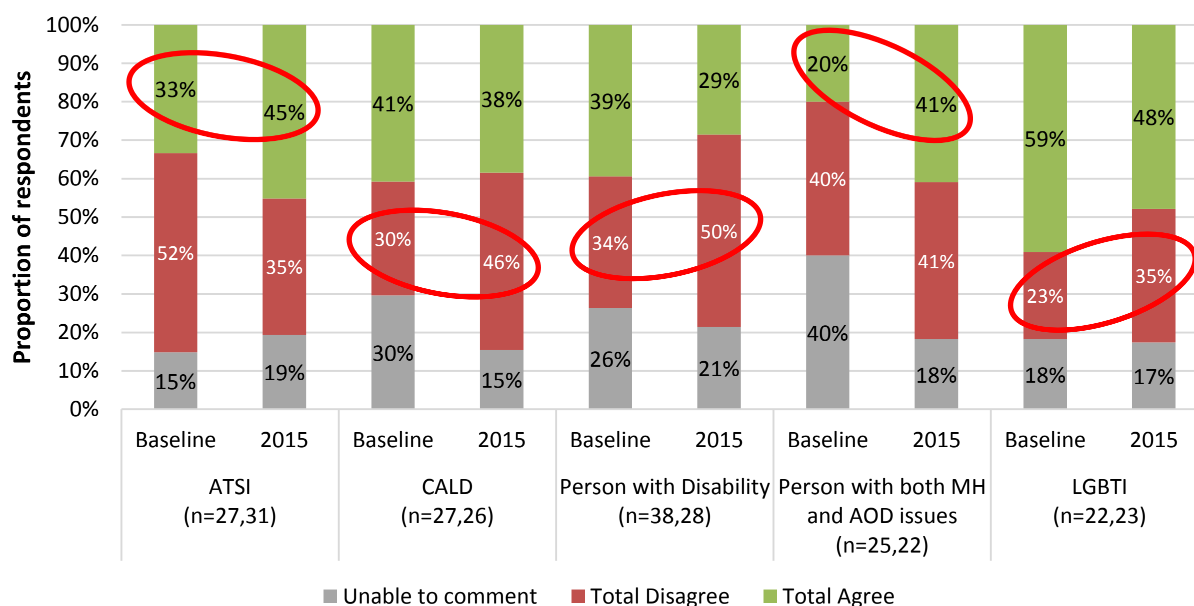
Exploring the trends for priority populations, Figure 23 highlights that a 12% greater proportion of Aboriginal and Torres Strait Islander people in the 2015 survey agreed that the QMHC is engaging the full range of stakeholders. In addition, the proportion of respondents who identified as having both mental health and substance misuse issues in agreement that the QMHC is engaging the full range of stakeholders approximately doubled between the Baseline and 2015 surveys. Conversely, the proportion of respondents disagreeing with this statement increased for those groups identifying as CALD, people with a disability and Lesbian, Gay, Bisexual, Transgender or Intersex (LGBTI).

These results correlate with the relative representation of these groups in the survey overall (see

Table 2). For example, those groups that were under-represented in the survey overall when compared to the expected population proportions (e.g. People with a disability, CALD people) tended to disagree that the QMHC is engaging the full range of relevant stakeholders. At least with respect to CALD groups, this was also consistent with stakeholder feedback obtained during the follow up consultations.

While caution must be taken in interpretation of these results due to the relatively small number of overall respondents, these results suggest the QMHC may need to improve its engagement with CALD and LGBTI groups and people with a disability.

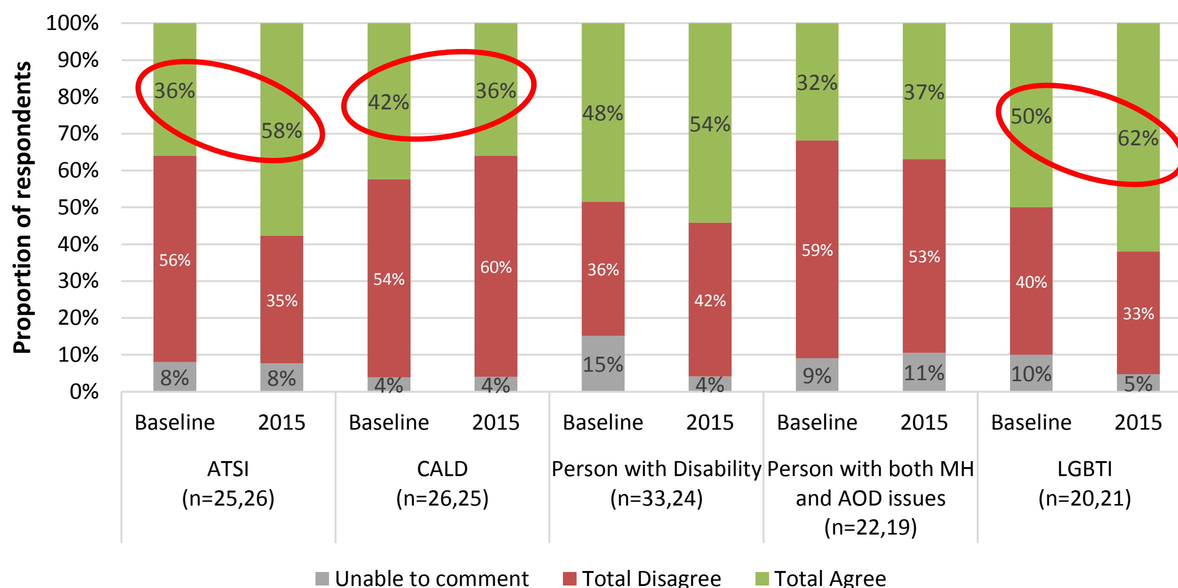
Figure 23: *"The QMHC is engaging the full range of relevant stakeholders"* – by priority population group



A higher proportion of 2015 survey respondents (compared to Baseline) identifying with most priority population groups agreed that they had had sufficient opportunities to provide input into the work of QMHC (Figure 24). These increases were most pronounced for ATSI groups (22%) and, surprisingly, LGBTI groups (12%). With respect to LGBTI respondents, this result is at odds with the decrease in proportions agreeing that the QMHC is engaging with the full range of relevant stakeholders (Figure 23).

These findings, coupled with others throughout the report, suggest the more reliable indicator of engagement is the question directly related to the respondents' own experience rather than that testing their opinion on an area that they may or may not have direct knowledge (e.g. in this case the range of stakeholders that the QMHC is engaging).

Figure 24: *"I have had sufficient opportunities to provide input into the work of the QMHC"* – by priority population group



The respondents identifying as CALD were the only priority population group for which a lower proportion (6% decrease in 2015 survey) agreed that they had sufficient opportunity to provide input into QMHC work.

4.3.1.4 To what extent is the Commission seen as taking an effective leadership role?

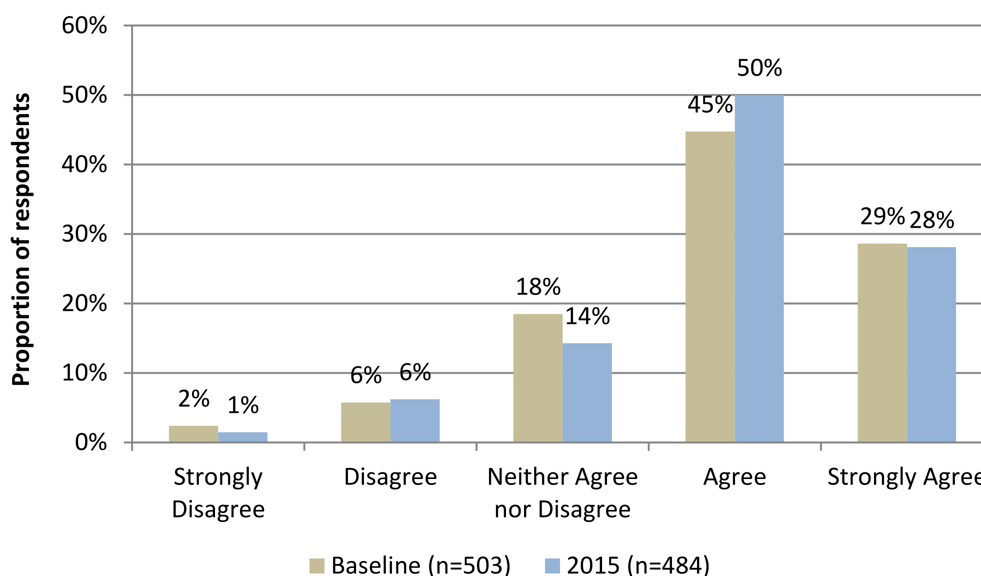
As a 'Backbone organisation'[11], the Commission is expected to take a leadership role in addressing key mental health, drug and alcohol issues and progressing the achievement of the *Shared Commitments* in the Strategic Plan.

Encouragingly, over three-quarters (78%) of question respondents in the 2015 survey viewed the QMHC as an important driver of reform of the mental health drug and alcohol system in QLD (Figure 25). This represents a small (4%) increase over the Baseline survey results.

> *"The presence of such a Commission helps raise the profile of Mental Health, Drugs and Alcohol issues as ones worthy of support and service provision"*
>
> - *2015 Survey respondent*

[11] Turner, S., Errecart, K., & A. Bhatt, A., (2013). Measuring backbone contributions to collective impact." *Stanford Social Innovation Review*.

Figure 25: "*I view the QMHC as an important driver of reform of the mental health, drug and alcohol system in QLD*"



With respect to the direct follow up consultations, the stakeholder feedback on this area was more varied. Some stakeholders viewed the QMHC as having a key leadership role to play in developing population-level measures of improved mental health wellbeing and fostering cross-governmental collaboration. On the other hand, others felt that it was not always not willing to "tackle government" on key issues and may be compromised in its ability to effect real change due to its own governance structure, lack of control over funding for service provision[12], and close alignment to Queensland Health.

It should be noted that in 2014/15 the Commission commenced a number of activities aimed at addressing these sentiments. Firstly, it commenced the development of a set of indicators designed to monitor progress towards achievement of the Strategic Plan. Secondly, it is progressing the formation of formal partnerships (including memoranda of understanding) with a number of organisations that have complementary objectives. Finally, the Commissioner and the Auditor-General discussed the potential for improving understanding and transparency in whether or not all monies allocated to Hospital and Health Services (HHSs) for mental health are spent on that program. Following these discussions, the Auditor-General has now included an audit of the management of mental health in 2016-17 and of forensic services in 2017-18 as part of the updated performance audit program.

4.3.1.5 To what extent is there agreement that QMHC is addressing the key issues for people with mental illness and/or issues with alcohol and other drug misuse?

A key requirement of a 'Backbone organisation' is the ability to effectively identify and understand the key issues that need to be addressed to achieve Collective Impact. The Commission's capacity to be effective in this areas is fundamental to its performance overall.

Figure 26 shows that over 70% of 2015 survey respondents believed that the QMHC has demonstrated a sound understanding of the mental health, drug and alcohol issues in QLD. This represents ~8% increase in this proportion over the Baseline survey results. Furthermore, over 60% of 2015 survey respondents believed the Strategic Plan identifies priorities that are important to them (see Figure 31 in Section 4.4.1).

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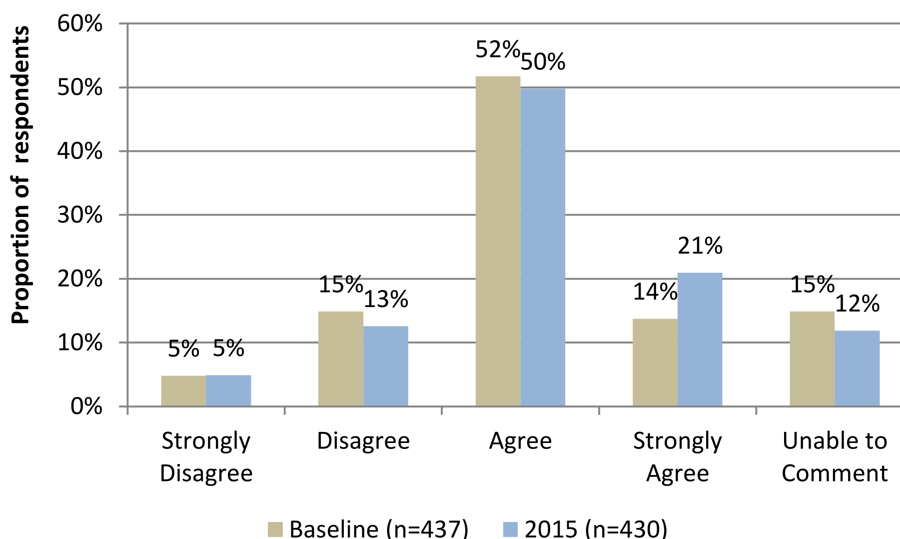
[12] In both the Baseline and 2015 surveys close to half of respondents indicated that the Commission should control funding for QLD mental health, drug and alcohol services (data not shown) indicating no change in this perception over the last year.

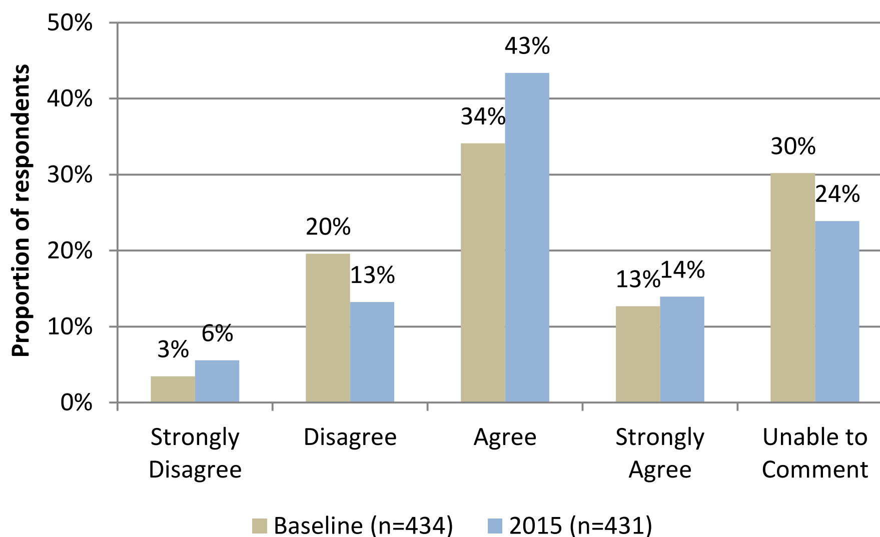
Figure 26: *"I believe the QMHC has demonstrated a sound understanding of the mental health, drug and alcohol issues in QLD"*



While identifying and developing a sound understanding of the key issues for the mental health, drug and alcohol sectors is critical, it is the translation of this understanding into benefits for consumers that most stakeholders articulated being interested in.

Compared to the Baseline survey, an additional 10% of respondents agreed that they believe people with mental health and/or substance misuse issues are benefitting from the QMHC's work (Figure 27). This is encouraging, particularly as the proportion of respondents providing a valid response increased by 6% and the proportion disagreeing declined 4%, between the Baseline and 2015 surveys.

Figure 27: *"I believe that people with mental health and/or substance misuse issues are benefitting from the QMHC's work"*



4.3.2 Summary

Almost 75% of survey respondents indicated being at least moderately familiar with the work of the Commission. However, while there was a 7% improvement since the baseline period, still less than a third of survey respondents agreed that there was a high-level of awareness of the Commission. Thus, despite the significant activities undertaken in this area over the last year, there is still more to do to improve broader awareness of the

Commission and its role. The findings from the stakeholder consultations indicate that engagement with HHSs is an area where the profile of the Commission could be strengthened significantly.

Encouragingly, over 75% of survey respondents saw the QMHC as credible and the majority of respondents indicated being interested in knowing more about the QMHC. Related to this may be the increase in the proportions of respondents indicating that the Commission is operating independently from government or QLD Health and other government agencies. However, the total proportion was still only around half of respondents in each instance who consider this to be the case. This suggests that there is still a perception amongst some stakeholders that the Commission is too closely aligned to QLD Health and government.

The Commission has interacted with its stakeholders through an extensive suite of engagement modes since its inception. In the 2014/15 period, this was further expanded to include a Facebook presence that appears to have been effective in capturing a new cohort of stakeholders, or at a minimum providing a new channel by which existing stakeholders can interact with the Commission and each other.

The most significant increase in proportion of survey respondents interacting with the Commission was observed for “QMHC Reports”. This suggests the Review, Research and Reporting activities undertaken in the 2014/15 were an effective means of engagement and are worthy of future targeted investment.

Overall, there was an increase in the proportion of survey respondents indicating that they felt the Commission is engaging the full range of relevant stakeholders. Similarly, typically more respondents felt that they had sufficient opportunity to provide input into the Commission’s work. There were a few exceptions to this trend, namely, fewer respondents representing either the employment or education sector agreed that the full range of stakeholders were being engaged and fewer respondents identifying with CALD groups agreed that they had sufficient opportunity to input into the QMHC’s work.

While the total number of respondents representing these groups was relatively small (ranging from 25-55), coupled with results elsewhere in the survey, it suggests that further work is required to better engage these groups. CALD groups noted similar concerns in the baseline report, suggesting that little progress may have been made in this area over the 2014/15 period. This should be given an increased focus in the 2025/16 period.

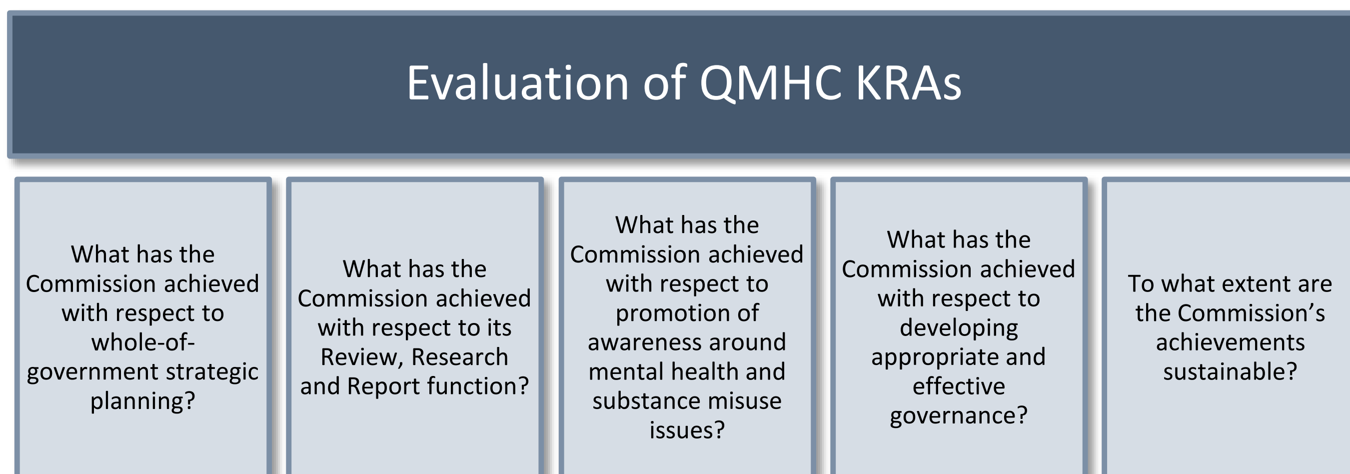
Almost 80% of survey respondents saw the QMHC as a key driver of reform (up 5% from the Baseline). However, some stakeholders expressed that the QMHC’s ability to effect ‘real’ change may be compromised by its own governance structure and lack of control over funding for mental health, drug and alcohol services. The QMHC has already started to address these concerns through strengthening the Mental Health and Drug Advisory Council with two additional support committees (one focused on ATSI issues, one focused on consumer, family and carer work) and liaising with the Auditor General to investigate ways to improve transparency of where funding for mental health, drug and alcohol services is spent.

Importantly, between the Baseline and 2015 surveys there has been an increase of 10% (to a total of 60% of respondents) in the proportion of respondents indicating that they agree people with mental health and/or substance misuse issues are benefitting from the QMHC’s work.

4.3.3 Recommendations

Recommendation 7: The Commission should continue to enhance opportunities for consumers, families and carers to engage with, and contribute to, the work of the QMHC.

4.4 QMHC KRAs

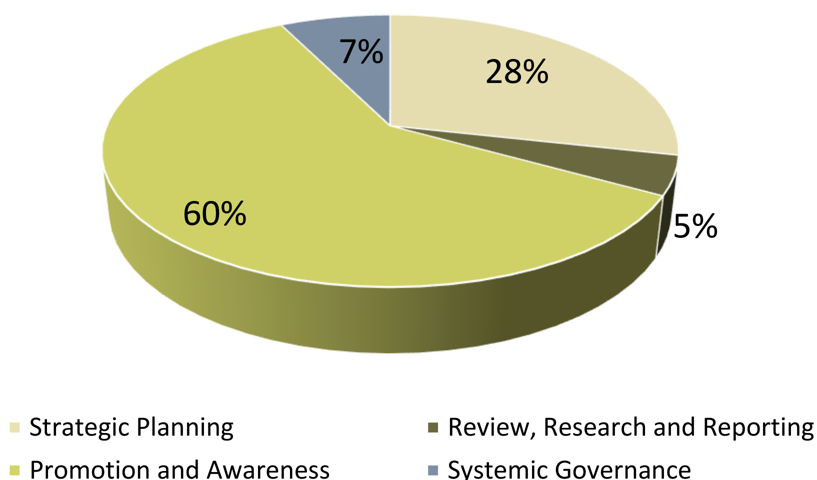


The QMHC Strategic Framework articulates four Key Result Areas (KRAs) in addressing its requirements under the *Queensland Mental Health Commission Act 2013*. These are:

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

Figure 28 provides an overview of the allocation of the 2014/15 QMHC KRA budget allocation to each of the specific KRAs. The KRA attracting the largest budget was the Promotion and Awareness[13], followed by Strategic Planning, Systemic Governance and finally the Review, Research and Reporting KRA.

Figure 28: Budget allocation by Key Result Area



The sub-sections below outline the evaluation findings relevant to each of these KRAs.

[13] It should be noted that over half of the budget allocated to the Promotion and Awareness KRA went to support implementation of two large programs (i.e. the BeyondBlue Program and the HHS Suicide Risk Management Project).

4.4.1 Strategic Planning

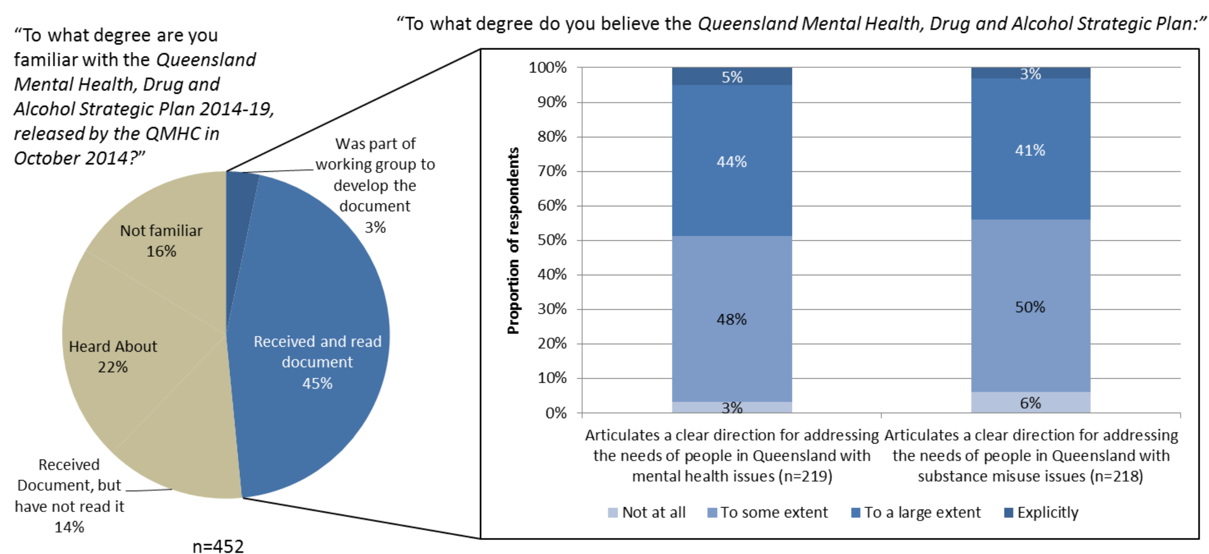
The Honourable Lawrence Springborg MP launched The Strategic Plan[14] on 9 October 2014, following extensive consultation with stakeholders across Queensland. In the initial consultations undertaken for Stage 1 of the evaluation between June-July 2014, many stakeholders commented that the release of the Strategic Plan would be a 'watershed' moment for the Commission and a document that would influence stakeholder perceptions of the Commission overall.

As such, the 2015 Survey included a specific focus on understanding stakeholder perceptions of the Strategic Plan in terms of its content and the potential for it influence change and benefits across the mental health, drug and alcohol system in QLD.

Figure 29 shows that only 16% of question respondents were unfamiliar with the Strategic Plan. Almost half had received and read the document (45%) and 3% indicated being part of the working group that developed the document. The remaining had either heard about the document (22%) or had received it, but not read it (14%).

Of those that had read the document, the majority indicated that the document articulates a clear direction for addressing the needs of people in Queensland with either mental health (97%) or substance misuse issues (94%) to *at least* some extent.

Figure 29: Familiarity with the Strategic Plan – overall

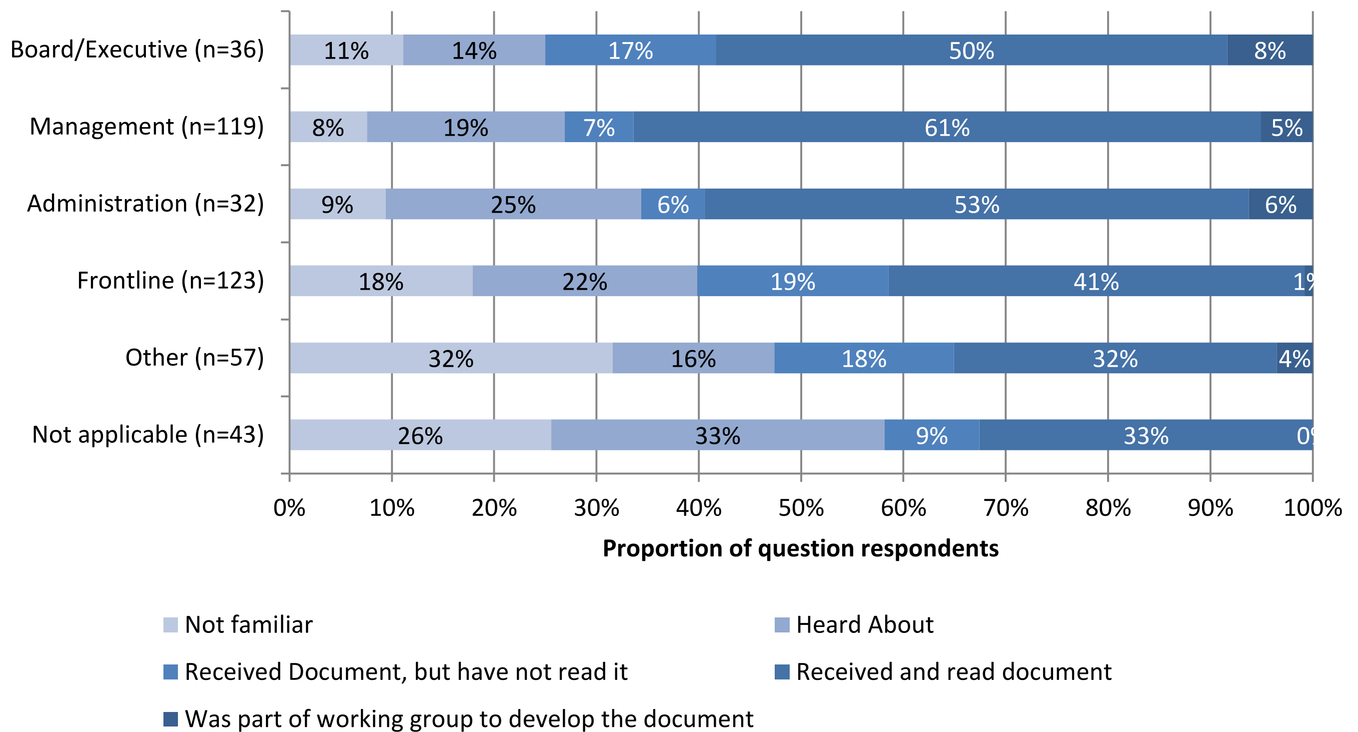


When looking at familiarity with the Strategic Plan by role, the majority (67%) of Board/Executive respondents reported having received the Strategic Plan, and 50% overall having read it (Figure 30). An approximately equivalent proportion (68%) of respondents identifying as Management had received the document, but an 11% higher proportion reported having read it. Fewer respondents indicating their role as Administration or Frontline reported having received the document (59% and 60%, respectively) or read it (53% and 41%, respectively).

This suggests that dissemination of the Strategic Plan to Frontline service providers, perhaps through different knowledge exchange products could be improved and there may be a need to promote the role of all stakeholders in contributing to the achievement of the outcomes articulates in the Strategic Plan so that all the relevant stakeholders can 'see themselves' in the plan. This is likely to occur as specific action plans are developed around key issues.

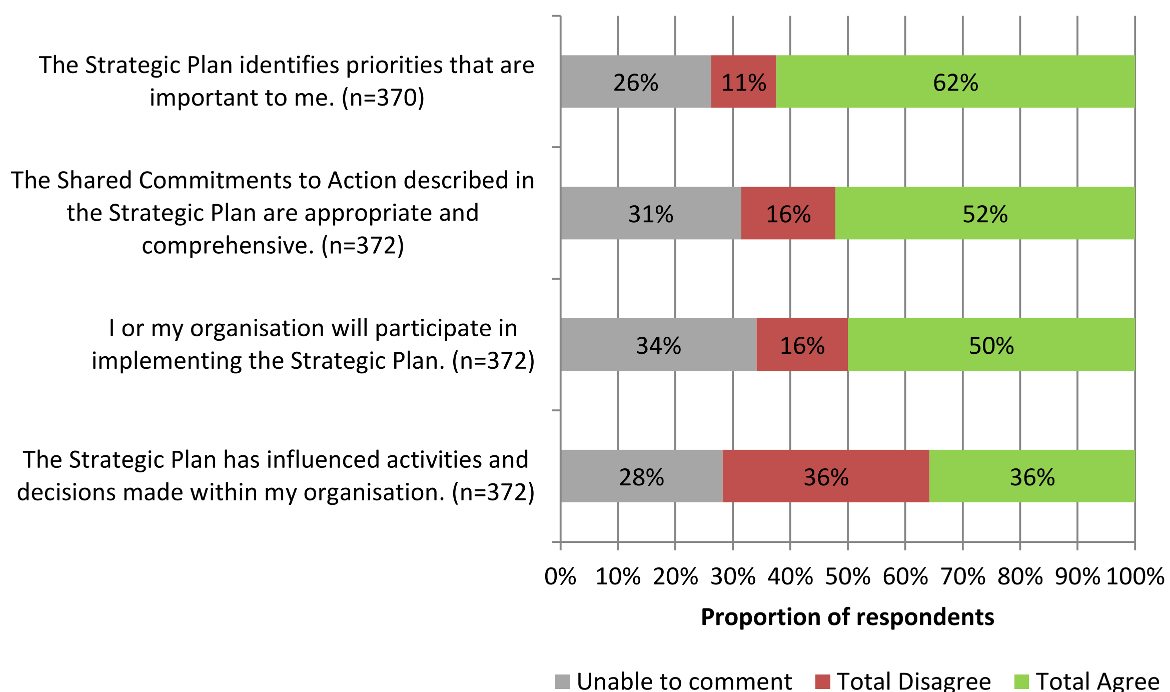
[14] *Queensland Mental Health, Drugs and Alcohol Strategic Plan 2014-2019*

Figure 30: Familiarity with Strategic Plan - by respondent role



The majority of question respondents (62%) indicated that they felt the Strategic Plan identified priorities important to them (Figure 31). About half each indicated that the Shared Commitments to Action are appropriate and comprehensive or that they or their organisation would participate in implementing the Strategic Plan. In both of these cases, close to a third of question respondents indicated being unable to comment. Unsurprisingly, there was no clear position on whether the Strategic Plan had influenced the activities and decisions made in respondent organisations; an equivalent proportion of question respondents (36%) disagreed as agreed. This will be an important indicator to examine over time.

Figure 31: Relevance of Strategic Plan



A theme identified in the stakeholder follow up (and through the free-text comments in the survey) suggested that while the Strategic Plan was seen to be comprehensive, and well compiled, it lacked the specificity many stakeholders were expecting to assist in providing a firm direction for the sectors.

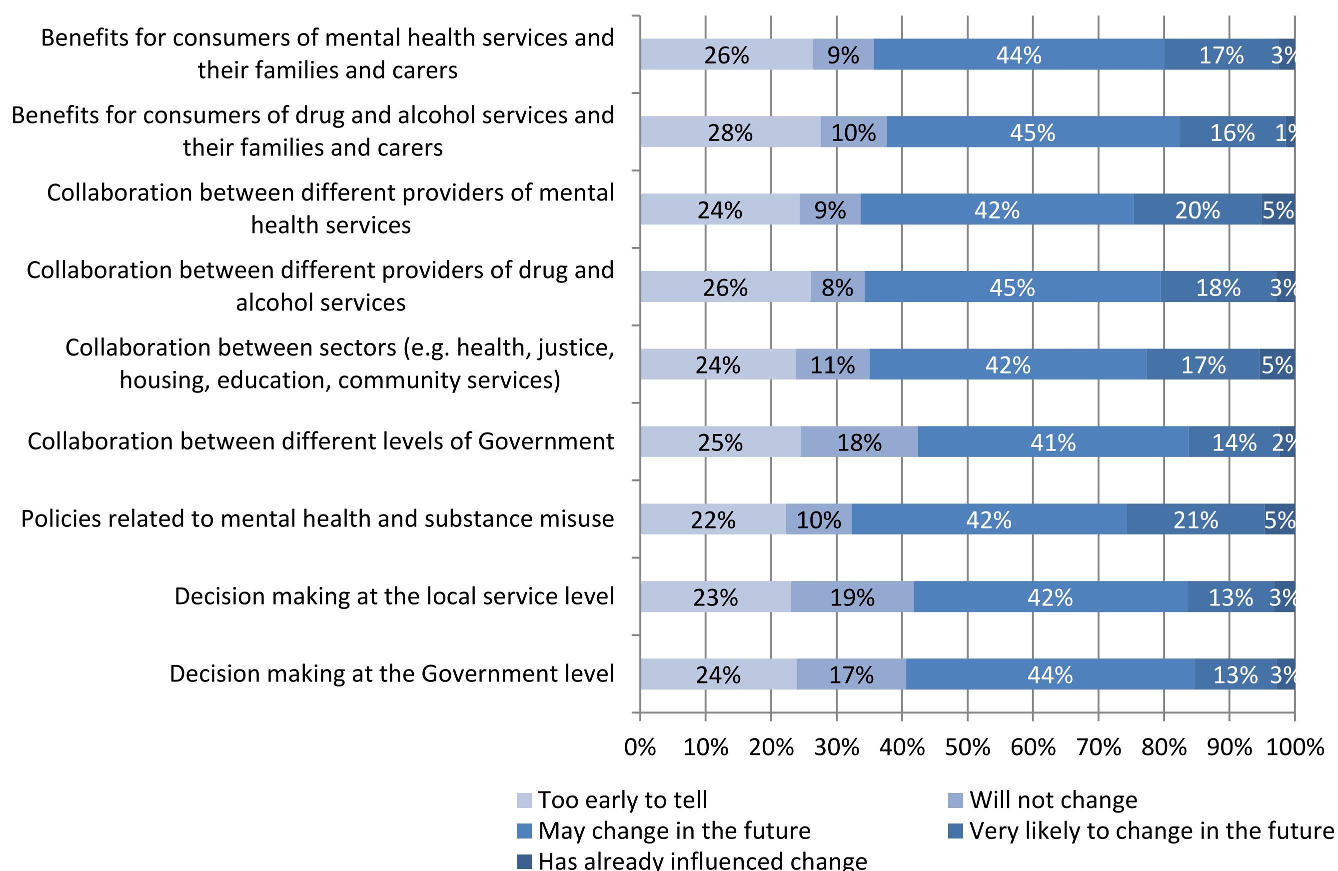
> *"The Strat plan could work when implemented in a realistic way. Words are words. Action is action."*
>
> - *2015 Survey respondent*

There is an expectation that more clarity in the form of an 'operational/action' plan (or plans) is required to effectively implement the Strategic Plan. A critical outcome for the Commission will be translation and linkage of the Strategic Plan to activities 'on the ground', and how the projects and partnerships are formed to support this will be key mechanisms for that translation.

The majority of respondents were positive that the Strategic Plan "may" change collective impacts in the future (41-45%) or "very likely to change" in the future (13%-21%) (Figure 32). Around a quarter of respondents felt it was too early to tell if the Strategic Plan would have an influence most indicators.

Respondents were most positive about changes in collaboration between providers of mental health services and between sectors. Conversely, respondents were less positive about the Strategic Plan influencing collaboration between different levels of government, and decision making at the local service and Government levels.

Figure 32: Potential influence of the Strategic Plan on key indicators

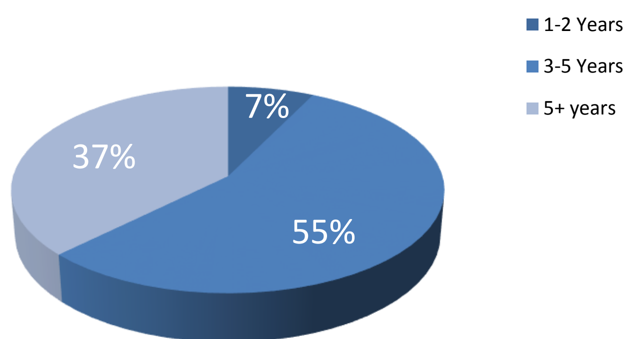


It was noted during the follow up consultations that, albeit less than a year since the Strategic Plan was released, stakeholders felt that overall they had observed little evidence that would suggest other government departments and non-government organisations (e.g. outside of health) have 'stepped up' to take carriage of certain elements of the plan. It was perceived that there is still work to be done to encourage influencers outside

of health to take ownership of progressing the Strategic Plan. The need to put work 'on hold' during the period leading up to the 2015 Queensland State Election may have contributed to this perception.

The majority of survey respondents (93%) indicated that they expected it to be three years or more (37% expected more than five years) before the wider impacts on the mental health, drug and alcohol sectors the Strategic Plan were observed (Figure 33). These expectations are consistent with the generally accepted view during the stakeholder consultations that the achievement of Collective Impacts is typically a longer-term prospect. Furthermore, such timeframes are consistent with those associated with Implementation Science[15].

Figure 33: Perceived timeframe to observe wider impacts of Strategic Plan



In addition to leading development and release of the Strategic Plan, the QMHC has led and/or contributed to a number of additional initiatives aimed at supporting the achievement of the objectives outlined in the Strategic Plan. These included:

- Commenced development of the Alcohol and Drug Action Plan, working with Queensland Network of Alcohol and other Drug Agencies (QNADA) (Shared Commitment 3)
- Supported the Department of Housing and Public Works to improve integration of social housing with mental health services and other social support services (Shared Commitment 5)
- Provided advice to the Department of Health on the Mental Health Drug and Alcohol Service Plan (Shared Commitment 7)
- Commenced planning for the development of an action plan for rural and remote communities
- Commenced work with QLD Police on options to improve interaction with people experiencing mental illness (Shared Commitment 5)
- Developed and administered the Stronger Community Mental Health Wellbeing Grants Program (Shared Commitment 3).

It was not possible to undertake a detailed review of these initiatives for the purposes of this report, and many are still in the relatively early stages of development. However, during Stage 3 of the evaluation, as far as possible, the effectiveness of these initiatives will be reviewed with stakeholders.

4.4.1.1 Summary

Close to half of survey respondents had read the Strategic Plan and of those that had, again close to half indicated that at least to a large extent it articulated a clear direction for addressing the needs of people with mental health and/or substance misuse issues in Queensland. Respondents indicating administration or frontline as their role

[15] Fixsen, D., Naoom, S., Blase, K., Friedman, R. & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature*. Louis de la Parte Florida Mental Health Institute Publication #231: Tampa, Florida.

were the least likely to be familiar with the Strategic Plan or have read it, suggesting a need to improve dissemination of the plan to these groups.

Most survey respondent agreed that the Strategic Plan identifies priorities that are important to them, suggesting that its content is relevant to most people. In direct consultations, while the Strategic Plan was seen to be comprehensive, and well compiled, it lacked the specificity many stakeholders were expecting to assist in providing a firm direction for the sectors. The Commission has already partnered with multiple agencies to develop action plans to guide activities to address the shared commitments.

Early perceptions by survey respondents were positive and most people felt that the Strategic Plan may at least change in the future benefits for consumers, families and carers, collaboration within and between sectors, policies and decision-making. Most people accepted that it would take 3-5+ years to observe the impact of the Strategic Plan.

4.4.1.2 Recommendations

Recommendation 8: Develop and implement a strategy for targeted dissemination of, and communication around, the Strategic Plan to Frontline service providers.

Recommendation 9: Further promote the message that implementing the Strategic Plan is ‘everyone’s responsibility’.

Recommendation 10: Continue to work with partners to deliver the objectives of the Strategic Plan and, where necessary, develop specific Action Plans to assist in clearly defining the activities (and responsible parties) to address the shared commitments to action.

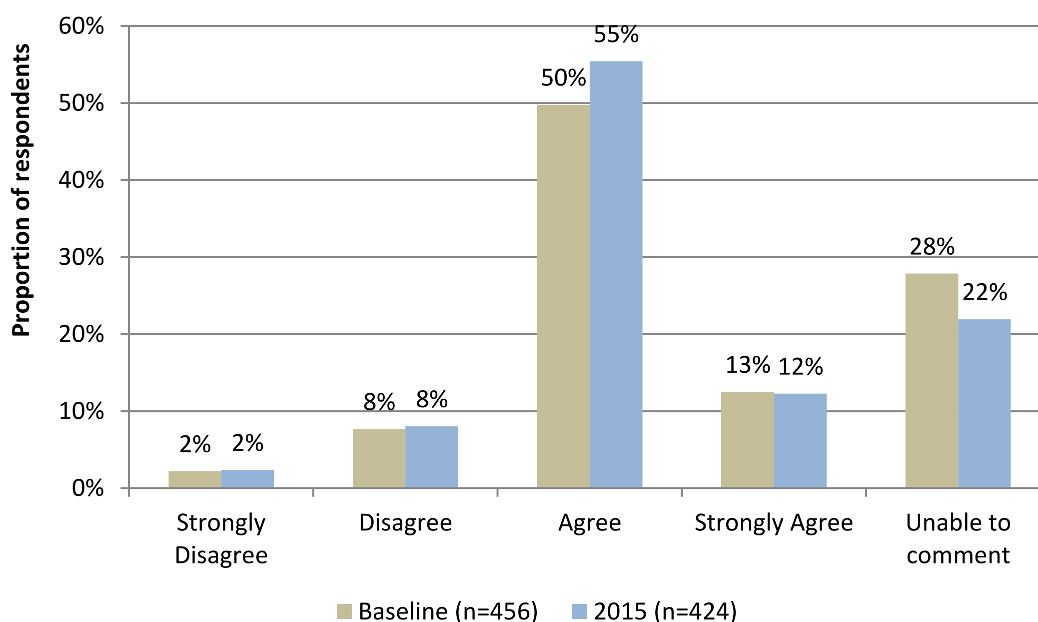
4.4.2 Review, Research and Reporting

The QMHC undertakes and commissions research in relation to mental health and substance misuse issues and reviews, evaluates and reports on the mental health and substance misuse system. These Review, Research and Report (RRR) activities are aimed at providing evidence-based advice to inform decision making on existing activities and in determining new initiatives.

> *"Targeted research and analysis on specific issues contributing to evidence base for policy development. Should continue to act as a research hub and disseminate information/data to agencies/service providers as needed for policy making purposes - this role could be expanded.."*
>
> - *2015 Survey respondent*

The majority of respondents in both the Baseline and 2015 Annual surveys (63% and 67% respectively) agreed that the RRR activities the QMHC is commissioning help to identify and respond to current and emerging issues and trends (Figure 34). Notably, only 10% of respondents in either survey disagreed with the statement (with the remaining selecting "Unable to comment").

Figure 34: *"The research, review and evaluation work the QMHC is commissioning helps identify and respond to current and emerging issues and trends."*



In line with the *Queensland Mental Health Commission Operational Plan 2014-2015*, the QMHC commissioned or produced the following key deliverables in the 2014/15 period:

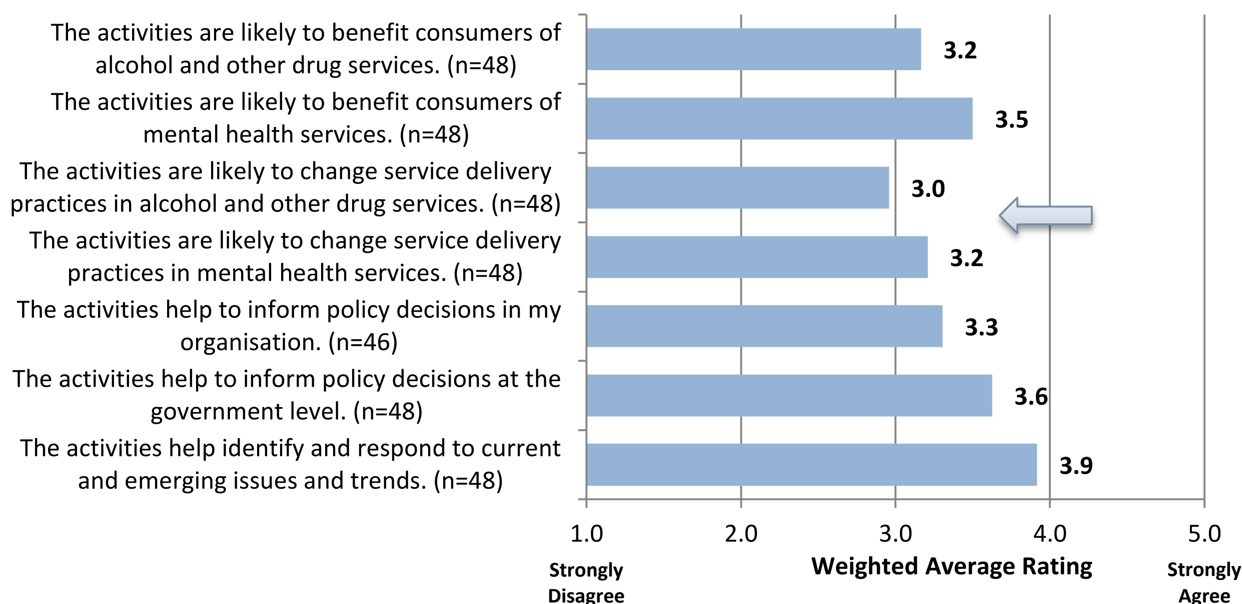
- Review on Social Housing
- Review of *Mental Health Act 2000*
- Research into Least Restrictive Practices and Locked Wards
- Evaluation of the EdLinq Program
- Research into Perinatal and Infant Mental Health.

This KRA was the focus of a specific 'Mini Survey' in March-April 2015 targeted at individuals who were involved in the development of one or more of the reports. A summary of the key survey results is presented below - more detailed results on each initiative may be sourced from the QMHC.

The first question of the survey allowed respondents to provide their perceptions on the impact of the QMHC's overall activities with respect to Review, Research and Reporting, not limited to the specific initiatives tested throughout the remaining survey questions.

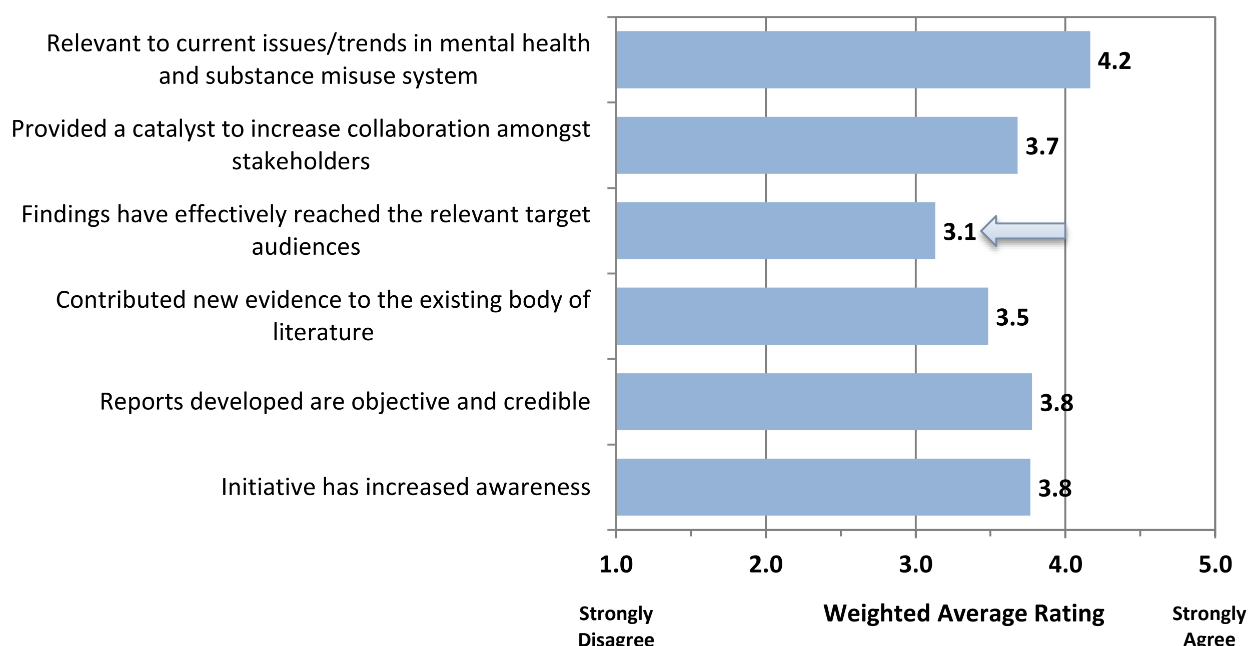
At an overall level, respondents were moderately positive, with ratings falling between 3.0 (Neither agree nor disagree) and 4.0 (Agree) for all but one question (Figure 35). The area with the lowest average rating was in relation to whether the activities were likely to change service delivery practices in alcohol and other drug services (arrow). Respondents were most positive with respect to the role that QMHC activities play in helping to identify and respond to current and emerging issues and trends (consistent with the annual survey results).

Figure 35: Overall assessment of QMHC RRR function



Invitees to the mini survey were asked a series of questions regarding the effectiveness of the five specific RRR initiatives listed above, the aggregated results of these questions for all the initiatives are presented in Figure 36.

Figure 36: Overall effectiveness of QMHC RRR initiatives



The weighted average scores for all the indicators surveyed were above the mid-point. The highest weighted average rating was for the relevance of initiatives to current issues/trends in mental health and substance misuse system (4.2). This positive result correlates with the results of a similar question asked in the annual survey (refer Figure 34).

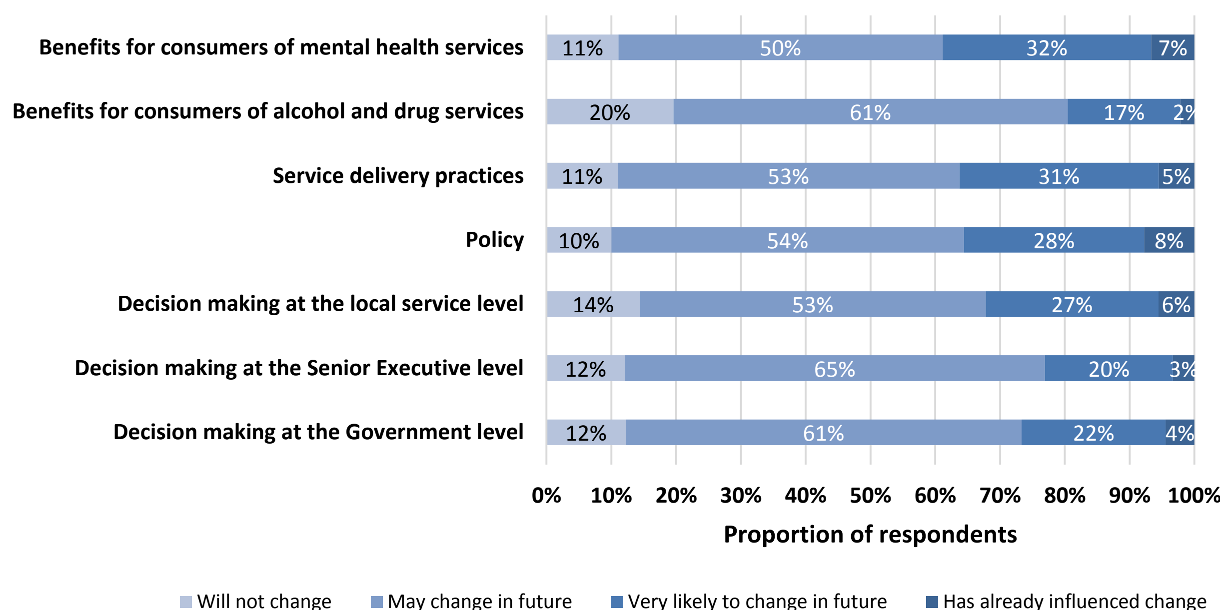
In contrast, the lowest weighted average rating was for initiatives effectively reaching the relevant target audiences, with most respondents neither agreeing nor disagreeing that this is being achieved. This suggests an opportunity to improve the communication and dissemination of the initiative findings to target groups, a finding that again is consistent with the results of the broader survey with respect to stakeholder familiarity with the Strategic Plan (refer Figure 30).

Consistent with the results of the mini-survey, follow up consultations suggested that stakeholders saw the specific initiatives undertaken under this KRA to be valuable in bringing different stakeholder groups together around a common issue and had the potential to provide a catalyst for further and broader collaboration between different stakeholders.

With respect to perceived impact, most respondents were non-committal about whether the RRR initiatives would afford benefits for consumers or change practices, policies or decision making, with between 50% and 65% indicating that they thought the initiatives 'may change things in the future' (Figure 37).

This result may be expected as, at the time of the mini-survey, most of the initiatives had only just been completed or were ongoing. In any case, the nature of the direct impacts surveyed mean that it may be unlikely that any changes would be observable until further into the future. This was echoed by the free-text survey commentary in which some respondents noted that there were indications that the initiatives would have a positive impact but it was 'too early to tell'.

Figure 37: Impact of QMHC RRR Initiatives



Encouragingly, between 17% and 32% of respondents thought that it was 'very likely' the initiatives would change things in the future. In addition, for each of the different areas of perceived impact, a small group of respondents indicated that they thought change had already been influenced. The highest proportion (8%) perceived that the initiatives had already influenced policy change around mental health or substance use issues. The lowest proportion of respondents (2%) indicated that the initiatives had already influenced benefits for consumers of alcohol and drug services.

4.4.2.1 Summary

Around 60% of 2015 survey respondents (up 5% from the Baseline) agreed that the RRR activities undertaken by the QMHC help to identify and respond to current and emerging issues and trends.

During the 2014/15 period, the Commission led or contributed to a number of initiatives that included the development and release of new research and reports around specific issues. The results of a targeted mini-survey around this KRA indicated that the majority of respondents felt the activities were likely to benefit consumers of mental health services and their families and carers, lead to changes in service delivery practices and inform policy at the government level. Unsurprisingly, since none of the 2014/15 initiatives focused explicitly on substance misuse issues, fewer respondents thought it was likely the initiatives would benefit consumers of alcohol and drug services, their families or carers. An important follow-up will be to determine the Knowledge Mobilisation activities that stakeholders feel would be critical in moving evidence to the field.

Encouragingly, most respondents to the mini survey thought the initiatives provided a catalyst to increase collaboration amongst stakeholders, that the reports were credible and objective and that the initiatives increased awareness of the issues. However, fewer respondents felt positive that the findings of the initiatives had effectively reached their target audiences.

Direct stakeholder feedback echoed these findings in being positive that the initiatives were relevant to current issues and were valuable in bringing various stakeholders together around a common purpose. However, reflecting the survey results, the key area identified for improvement was dissemination of the research/initiative findings to the target audiences.

4.4.2.2 Recommendations

Recommendation 11: Continue to identify and invest in targeted research that builds the evidence base around mental health, drug and alcohol issues.

Recommendation 12: Research leading practice approaches for the effective dissemination of knowledge products and develop product-specific strategies for release and communication of all future knowledge products.

4.4.3 Promotion and Awareness

The QMHC plays a role in promoting and facilitating the sharing of knowledge and ideas about mental health and substance misuse issues to support and promote strategies that:

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

The *QMHC Operational Plan 2014/15* identified a number of key deliverables in this KRA for the 2014/15 period. These actions contribute to progressing the Strategic Plan and include:

- **Developing and supporting implementation of a Primary Prevention and Early Intervention (PPEI) framework**
  - Supporting organisations to improve mental health and wellbeing
  - Completing an EdLinQ review with Education
  - Promoting volunteering in the mental health sector
  - Continuing to support the National "Beyond Blue" Program
- **Developing suicide prevention action priorities** which include:
  - Developing a suicide prevention framework for Queensland
  - Scoping future data needs for suicide prevention
  - Evaluating the HHS suicide risk project officer program
  - Piloting a new place-based approach in up to three communities
- **A focus on Aboriginal peoples and Torres Strait Islanders**:
  - Supporting the development of a community social wellbeing model
  - Supporting the National Empowerment Program (stages 2 &3)
  - Reviewing the change in practice arising from the implementation of selected coronial inquests

Table 4 provides a summary of the QMHC's activities and outcomes in the 2014/15 year in achieving these deliverables.

Table 4: Summary of Promotion and Awareness activities 2014/15

Activities	Outputs	Outcomes/Progress
Primary Prevention and Early Intervention (PPEI)		
Development of *Mental Health Awareness, Prevention and Early Intervention Action Plan*	Discussion Paper released	Action Plan - under development – due October 2015
Gregor Henderson Forums (cross-governmental consultations) on mental wellbeing	8 groups of forums	310 government, non-government and community representatives engaged in workshops and forums to consider effective approaches and ways forward for better mental wellbeing and reduced mental illness. Over 120 people also attended a public lecture.
EdLinQ Program	Implementation and reporting on EdLinQ Cross- Sectoral Workforce development Program	15 two-day cross-sectoral workforce development workshops delivered across Queensland. New workshop topic for 2015/16 developed and piloted.
	Finalised EdLinQ evaluation	Evaluation confirmed program benefits for participating schools, health and mental health services and school-health partnerships. Also identified, reduced crisis intervention due to earlier identification of mental health needs, improved access and reduced waiting times for specialist support, especially in times of crisis.
Beyond Blue Grant Program	Funding provided for the National Depression Initiative Commissioner is an observer on *beyondblue's* Board	Funding agreement between Queensland Government and *beyondblue* ended 30 June 2015. The Commission is preparing the terms of a renewed agreement to continue the partnership with *beyondblue*.
Perinatal and Infant Mental Health Program	Partnered with Women's Health QLD Wide to develop capacity for peer-driven perinatal and infant mental health education and support.	Implementation underway
Suicide Prevention		
Development of Action Plan for suicide prevention (including future data needs)	Action plan under development Commission hosted three Strategic Conversations in early 2015 and targeted consultations (including people with lived experience) and released a public discussion paper.	Priority areas for action have been identified to be built into the Plan.
Implement and Report on HHS Suicide Risk Management Project	Funding provided to HHS SRAMP	Evaluation commissioned for reporting late 2015

Activities	Outputs	Outcomes/Progress
Implementation and reporting of Queensland Suicide Register	Funding provided to Australian Institute of Suicide Research and Prevention (AISRAP) to collect, analyse and report on suicide mortality data.	The Commission has been working with the AISRAP to identify ways to improve the timeliness and accessibility of suicide mortality data and information. Commission also convened the Queensland Advisory Group on Suicide to consider ways to improve the early detection and communication of systemic trends and issues in relation to suicide across Queensland.
Research into farmer suicide	Partner on the Australian Research Council Linkage project *Influences on Farmer Suicide in Queensland and New South Wales.*	Research underway.
Aboriginal and Torres Strait Islander people		
Continue support for the National Empowerment Program (stages 2&3)	Support services, community worker training and healing program development for the communities of Cherbourg and Kuranda	A formative evaluation was undertaken in 2015 that indicated that the NEP is making a positive difference in the lives of individuals and families in Cherbourg and Kuranda.
Options to reduce suicide in ATSI young people in Townsville	Project underway to assess the need for a 24 hour primary health care service and recommend options to improve access to services for young Indigenous people in Townsville	Commenced. Planned for continuance into 2015/16
Develop KPIs across continuum of care for ATSI mental health, social and emotional wellbeing, alcohol and drugs	Contractor consortium engaged following recommendation of the MHDAC's ATSI committee	Consultation underway. Project due for completion early September 2015.
The Wharerata Declaration[16]	The Commission hosted a consultation on the adaptation of the Declaration with ten Indigenous Queensland leaders and influencers and sent the feedback to the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) for consideration in the adaptation of the Wharerata Declaration.	NATSILMH is expected to finish the adaptation process by the end of 2015.
Other		
Promotion of Mental Health Week		The Commission has worked with sector stakeholders and partners to develop a strategy for Mental Health Week 2015-17 to strategically improve and augment the event. The Commission has also coordinated a Reference Group and Working Group to advance MHW15

[16] The Wharerata Group of Indigenous mental health leaders from Canada, the United States, Australia, Samoa and New Zealand developed the Wharerata Declaration in 2010. The Declaration is about the importance of Indigenous leadership in addressing the common mental health challenges faced by Indigenous peoples around the world.

Activities	Outputs	Outcomes/Progress
Promotion of World Suicide Prevention Day		The Commission has supported Roses in the Ocean to develop a strategy for WSPD in Queensland, and extend and improve sector and community engagement with WSPD
Website traffic	Gradual development throughout 2014/15 and major overhaul planned for 2015/16	29,400 sessions (100% increase over 2013/14) 18,800 visitors (100% increase over 2013/14) 81,700 page views (14% increase over 2013/14)
Social media	Twitter campaigns on key topics	292 followers (420% increase from inception to end of 2014/15 year) 52, 500 impressions (number of users who saw the tweet) This translated to 5, 642 visits to the Commission's profile, 113 mentions and 223 new followers. The Commissioner's own Twitter account also attracted and additional 95 followers, 2, 369 profile visits and 28, 145 impressions from 128 tweets.
	Facebook page launched	442 'page likes' 6, 807 'post views'

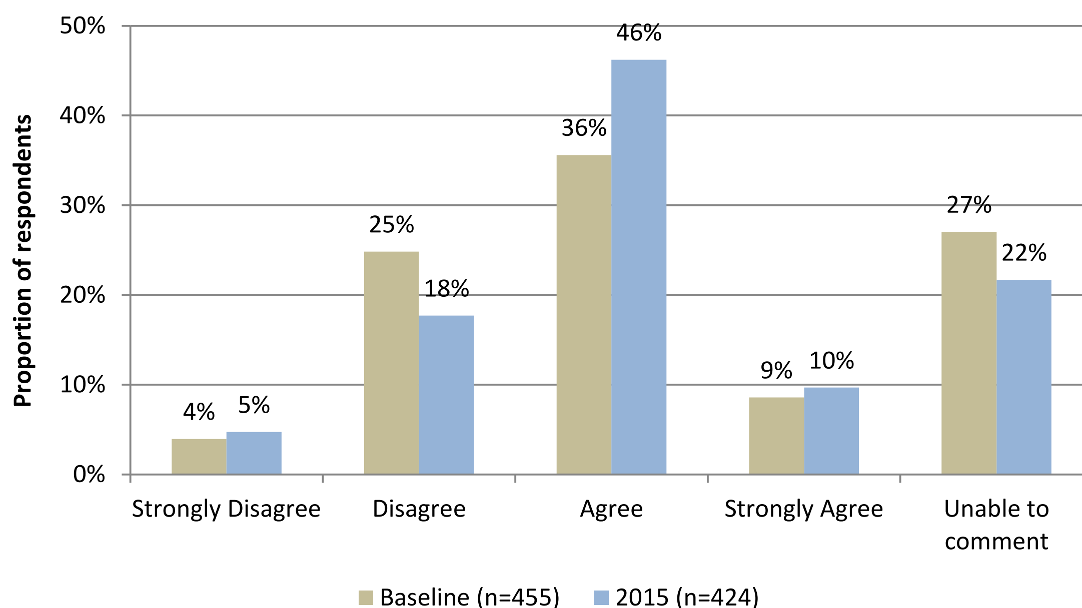
Figure 38 shows that 56% of 2015 survey respondents agreed that the promotion and awareness work being undertaken by the QMHC is increasing community awareness and reducing stigma and discrimination, an increase of 11% compared to the Baseline Survey. Suggesting that reasonable progress has been made in this KRA over the last year.

"Promotion of Mental Health within the broader community"

"Promoting individual rights, Educating about stigma"

- *2015 Survey respondents*

Figure 38: *"The promotion and awareness work being undertaken by the QMHC is increasing community awareness and reducing stigma and discrimination".*



4.4.3.1 Summary

The QMHC commenced and completed a large number of initiatives under this KRA in the 2014/15 period. However, many are too early in their development cycle to assess their impact. The key question on the annual survey on this KRA did however indicate that stakeholder perception of this area has improved in the last year with 56% of respondents (up 11% from the Baseline) agreeing that the promotion and awareness work undertaken by the QMHC is increasing community awareness and decreasing stigma and discrimination.

This KRA will be the subject of a targeted assessment in Stage 3 of the evaluation.

4.4.3.2 Recommendations

No recommendations identified at this stage.

4.4.4 Systemic Governance

Aside from its role in strengthening statewide governance with respect to mental health and substance misuse through the development and monitoring of the Strategic Plan, the QMHC is focused on two key activities under this KRA:

- Support and operation of the Mental Health and Drug Advisory Council (MHDAC), and
- Further development of processes to enhance the involvement of consumers, families and carers in contributing to systemic reform.

4.4.4.1 Queensland Mental Health and Drug Advisory Council

The MHDAC has a key role in supporting effective governance of the QMHC, and was convened on six occasions over the 2014/15 period to:

- provide input into research and evaluation initiatives

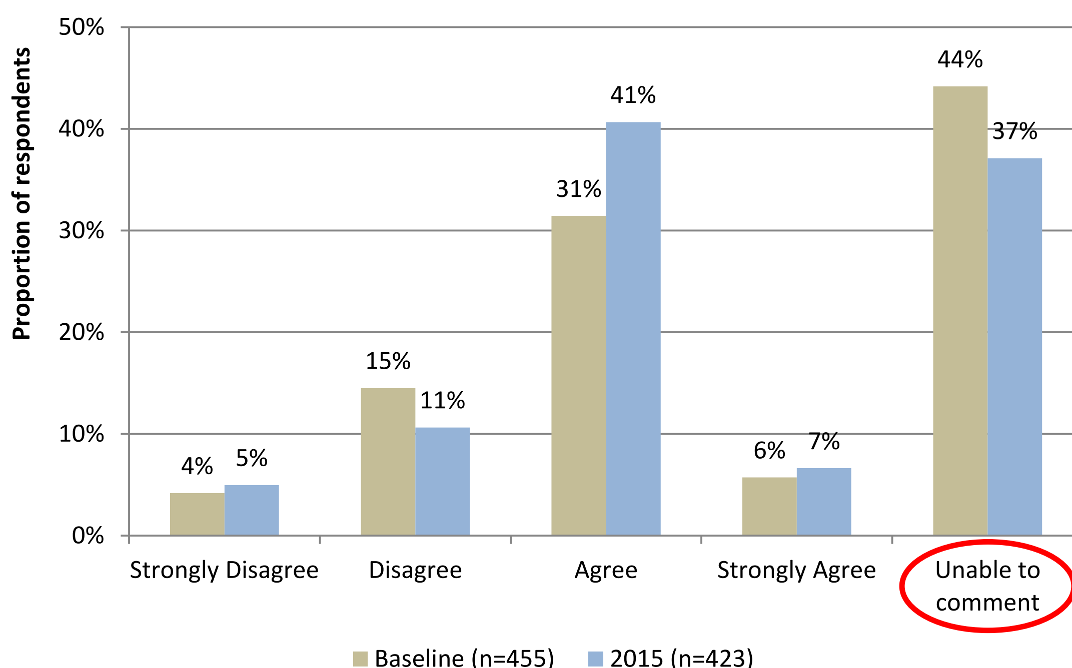
- consider the findings and recommendations of the Baseline evaluation report
- provide comment and guidance on how to deal with emerging or immediate issues arising (e.g. police shootings)
- consider the role and composition of the Council's Consumer, Family and Carer and ATSI committees.

A review of the Communiques from these sessions indicate that they appear to have been productive meetings and have effectively supported the Commission in effecting its role.

The largest proportion of 2015 survey respondents (48%) agreed that the MHDAC is providing effective advice to drive appropriate reform (Figure 39). This represents an 11% increase over the Baseline survey, suggesting there has been an improvement in the profile of the MHDAC over the last year. However, over a third of 2015 respondents (37%) still indicated being "unable to comment", suggesting there is still an opportunity to further improve understanding of the MHDAC's role, activities and how it interfaces with the Commission and the broader mental health, drug and alcohol system.

> *"More news about the work of the Council and its representatives would be helpful in understanding how the Council informs the work of the QMHC"*
>
> - *2015 Survey respondent*

Figure 39: "*The Queensland Mental Health and Drug Advisory Council is providing effective advice to drive appropriate reform*"



4.4.4.2 Consumers, families and carer contributing to systemic reform

Over the past three decades or so, the movement towards consumer-centred health care, supported by carers and families, has evolved from an idea to practice. Notably, the Australian Commission on Safety and Quality in Healthcare (ACSQHC) publishing *National Safety and Quality Health Service Standard 2: Partnering with Consumers* to ensure that healthcare organisations use consumers' experience and expertise to deliver safe and high-quality health care. Furthermore, Standard 3 of the *National Standards for Mental Health Services (2010)* dictates that consumers and carers are actively involved in the development, planning, delivery and evaluation of mental health services.

The model in Figure 40 below highlights the centrality of the consumer to the development of their care intervention and overall practice, considering the principles of co-design.

Figure 40: Consumer-centred mental health and drug system design

A key mandate of the Commission is to directly engage, and promote engagement of, consumers, families and carers in the systemic governance of the mental health and drug services sectors in Queensland. In addressing this critical aspect of its role, the Commission undertook a number of specific initiatives in 2014/15, including:

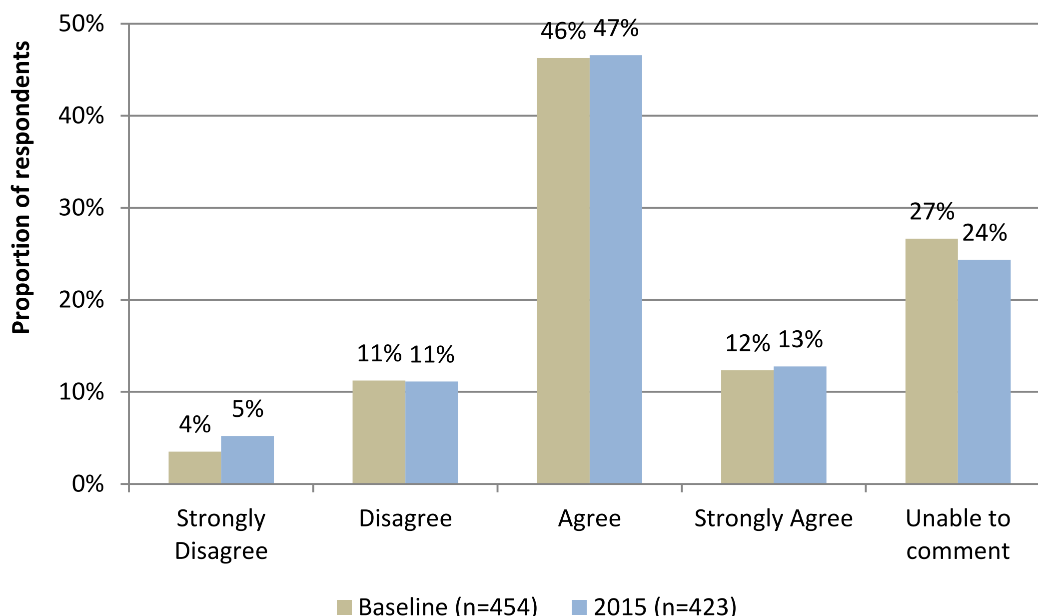
- Convening a Consumer, Carer and Family Committee of the MHDAC
- Supporting the National Consumer Carer Forum
- Engaging a contractor to map consumer, family, and carer engagement in the public, private and NGO sectors
- Engaging a contractor to develop a set of best practice principles for consumer, family, and carer engagement
- Ensuring input from people with lived experience to all Commission projects.

Approximately 60% of respondents in both the Baseline and 2015 surveys 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 41).

It is positive that an equivalently high proportion of respondents in the 2015 survey agree that this engagement has been sustained since the Baseline. However, it is also somewhat surprising that further gains do not appear to have been made in shifting the perceptions of key stakeholders, given the targeted initiatives undertaken in the 2014/15 period to address this KRA. Almost a quarter of respondents to this question indicated being ‘unable to comment’, suggesting that this group of respondents may not be clear on whether the QMHC are utilising the views of people with lived experience, their families carers and support people to inform planning and decision making.

Three possible explanations for this finding are that 1) these respondents are unclear on the QMHC’s planning and decision-making processes more broadly, 2) have not observed evidence of consumer, family, and carer views being translated into actions or 3) these respondents do not connect their input with the Commission’s activities.

Figure 41: ***"The QMHC is utilising the views of people with lived experience, their families, carers and support people to inform planning and decision making"***



This finding is also somewhat inconsistent with other survey findings that show greater proportions of consumers, family members and carers (6%, 5% and 10%, respectively) agreeing that they had sufficient opportunity to provide input into QMHC work (Figure 22).

4.4.4.3 Summary

In supporting the governance of the Commission, the MHDAC was engaged six times in the 2014/15 period to provide advice to the Commission on specific issues. The survey results indicate an 11% increase in the proportion of respondents agreeing that the MHDAC is providing effective advice to drive appropriate reform. However, with still 37% indicating that they were unable to comment, there is still an opportunity to improve the wider understanding of the MHDACs role, activities and interface with the QMHC. The free-text survey responses indicate this may be welcomed by stakeholders.

While the relatively high proportion (60%) has been maintained since the Baseline, there has been negligible change in the proportion of survey respondents that agree the QMHC is utilising the views of people with lived experience, their families, carers and support people to inform planning and decision-making, despite significant activity in this area in the 2014/15 period. This may suggest that the actual inclusion of consumers, families and carers is not at fault. Rather, these perceptions may be related to a lack of awareness/understanding of explicitly how the views of CFCs are incorporated to inform the QMHC's planning and decision-making. As such, Recommendation 16 made in the Baseline Report still applies and is referenced (in slightly modified form) as Recommendation 17 in Section 4.4.4.4 below.

4.4.4.4 Recommendations

Recommendation 13: The Commission should publish the MHDAC's terms of reference on the QMHC website and communicate its role and function as often as appropriate in other forums to increase awareness.

Recommendation 14: The Commission should develop a simple graphic depicting the relationships between the Commission, the MHDAC (and the ATSI and CFC committees), Minister for Health and QLD Health to improve the wider understanding its role and governance.

Recommendation 15: Increase communication about how the QMHC is involving consumers, their families and carers in planning and decision-making.

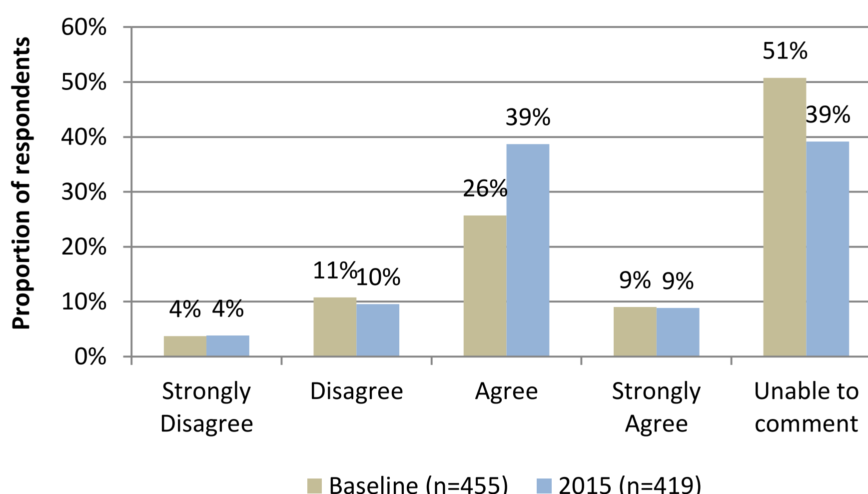
4.4.5 Sustainability of reforms

At the Baseline Survey, few stakeholders were clear on whether the QMHC was driving sustainable reforms, with over half of respondents indicating being unable to comment (Figure 42). This may be expected given that at the time of the Baseline Survey the QMHC was still in the early stages of its inception. A year on, the 2015 survey results indicate that more stakeholders (48% of respondents) are starting to shift toward a view that suggests a greater degree of comfort with the sustainability of reform (13% higher than the Baseline).

However, a high proportion (39%) of 2015 survey respondents also reported being "unable to comment". In other words, it may be still "too early to tell" for a large proportion of stakeholders whether the reforms will be sustainable or not. Again, this may not be surprising, taking into account that most stakeholders anticipated 3-5+ years to be required before the wider impacts of the Strategic Plan are observed (Figure 33).

> *"Too soon to tell - Little from the iniatived [sic] have moved to review level."*
>
> - *2015 Survey respondent*

Figure 42: *"The reforms the QMHC is driving will be sustainable over the long term"*



4.4.5.1 Recommendations

No recommendations identified.

4.5 Collective Impact

Evaluation of Collective Impact

To what extent has the QMHC influenced social policy around MH and AOD issues?	To what extent have the activities of the Commission influenced changes at the government level?	To what extent have the activities of the Commission influenced changes at the agency/service provision level?	To what extent have impacts for consumers, families and carers been influenced by the activities of the Commission?

4.5.1 Key Findings

Collective Impact has been defined as multi-sectoral partners working towards solving a particular social problem[17]. It requires a balance between the unique contributions of each partner and the co-ordination of activities that create mutual reinforcement, while maintaining a differentiation that allows for an innovative approach to the issue at hand.

Stakeholder consultations undertaken during the Baseline reporting period indicated that there is a broad expectation that the Commission drive mental health and drug sector reform across QLD and develop the framework against which the various parties can be held to account for system improvement. The resultant Collective Impacts are expected to be measureable at three levels: Government policy, agency/service provision and impacts for individual consumers, families and carers.

This section summarises the evidence for the Commission's progress in facilitating the achievement of Collective Impacts.

As described in the Theory of Change (Figure 2) the evaluation has focused primarily on the progress made toward the achievement of results that are within the Commission's direct sphere of influence or control. To this end, the Commission has undertaken a range of targeted initiatives in the 2014/15 period, many of which are explored in the preceding sections of this report.

As the recent evaluation results have shown (Figure 33 and Figure 42), it is likely to be too early to measure the impact of many of the Commission's activities. However, there are early indications that progress is being made.

Table 5 summarises the Commission's initiatives against each of the key evaluation questions in this domain, along with the relevant key findings of the evaluation.

[17] Boyce, B (2013). Collective Impact: Aligning organisational efforts for broader social change. *Journal of the Academy of Nutrition and Dietetics, 113*, 495 – 497.

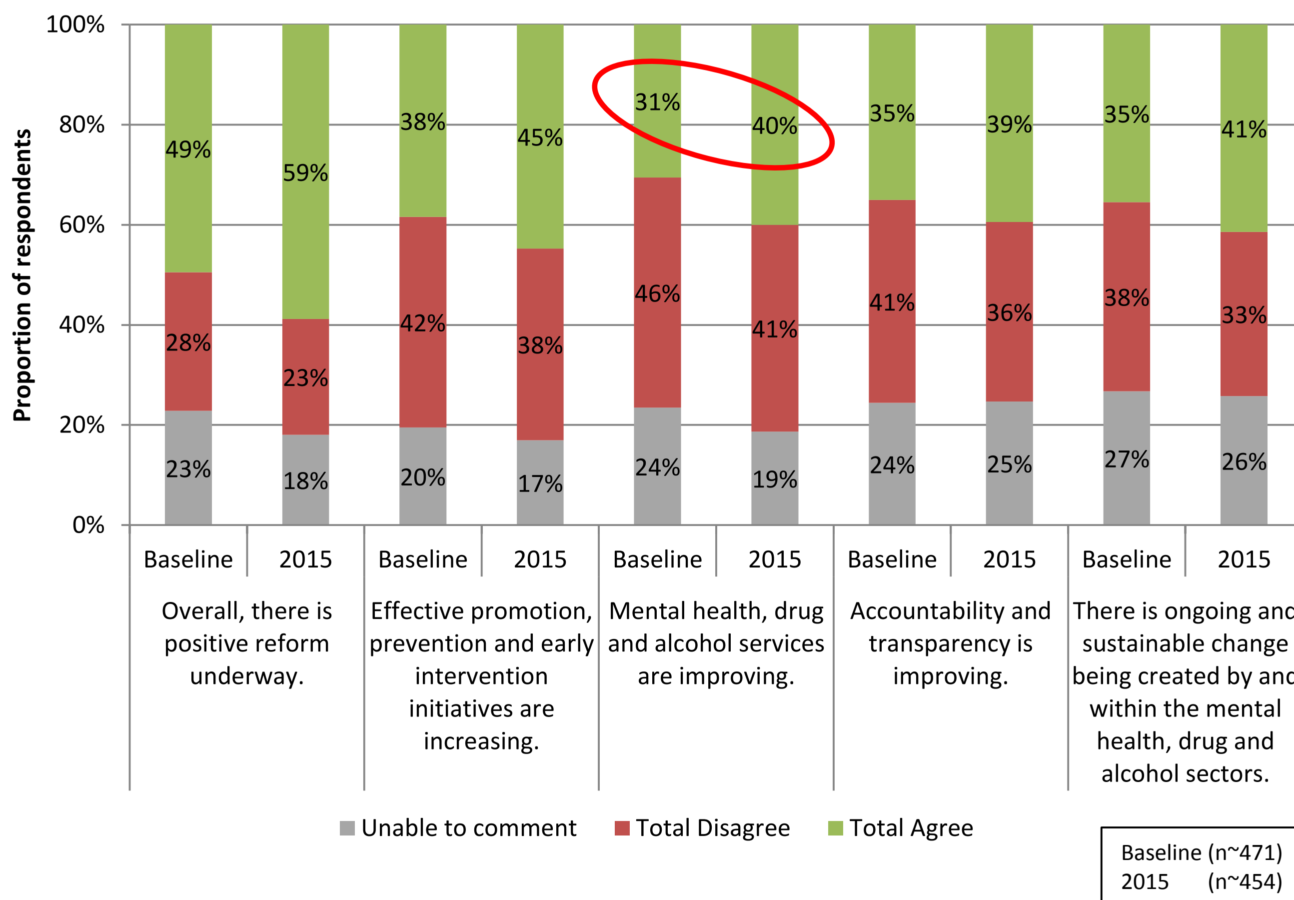
Table 5: Mapping of progress toward Collective Impacts

Progress toward Collective Impacts				
Direct Control	Direct Influence		Indirect Influence	
Initiatives	Influence on social policy	Changes at Government level	Changes at service provision level	Impacts for Consumers, Families, Carers
Development and release of *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019*				
Ordinary report on social housing				
Options for reform least restrictive practices (including locked wards)				
Research into Perinatal and Infant Mental Health				
Review of *Mental Health Act 2000*				
Input into the Mental Health Drug and Alcohol Service Plan				
Initiated Community Wellbeing Grant Program				
Commenced development of indicators to measure progress towards achievement of outcomes in the Strategic Plan	Too early to measure impact			
Released discussion paper for Action Plan for Suicide Prevention Action Plan	Too early to measure impact			
Released discussion paper for Action Plan for Awareness, Promotion and Early Intervention Action Plan	Too early to measure impact			
Commenced development of Action Plan for rural and remote priorities	Too early to measure impact			
Released discussion paper for Action Plan for Alcohol and Drug services	Too early to measure impact			
Engaged contractor to map CFC engagement in the public, private and NGO sector	Too early to measure impact			

Progress toward Collective Impacts				
Direct Control	**Direct Influence**		**Indirect Influence**	
Initiatives	**Influence on social policy**	**Changes at Government level**	**Changes at service provision level**	**Impacts for Consumers, Families, Carers**
Key evaluation findings	Too early to measure impact but the following progress has been made: • Report on Social Housing tabled to Parliament • Report on Least restrictive practices provided to Minister for Health, DG of Health and Director of Mental Health Close to 80% of survey respondents see the QMHC as an important driver of reform.	There appears to have been in strengthening of the partnerships across sectors Too early to tell definitively, but early indications are that stakeholders expect the Strategic Plan may, in the future, impact benefits for consumers, families and carers, collaboration, policies and decision-making.	Stakeholder feedback suggests that changes in the agency/service provision level will take the longest to effect and observe and work is still required in this area. As an example, survey respondents were non-committal as to whether the Strategic Plan would influence changes in their organisation.	Too early to directly measure impact but the evaluation found the following: • The majority of survey respondents indicated that: ○ people with mental health and/or substance misuse issues are benefitting from the QMHC's work ○ The QMHC is utilising the views of CFCs to inform planning and decision making

Although not definitive, the 2015 survey results indicate an improvement in the high-level indicators of mental health, drug and alcohol system reform relevant to the Commission's mandate. Almost 60% of 2015 survey respondents indicated that there is positive reform underway (up 10% over the Baseline survey), while for most other indicators, the largest proportion of 2015 respondents were positive about the progress (a reversal from the Baseline where the largest proportions disagreed with the statements) (Figure 43). The only exception was the indicator "Mental health, drug and alcohol services are improving" for which almost equivalent proportions of 2015 survey respondents agreed as disagreed with the statement. However, while still representing the minority, this represented a 9% increase (2015 vs Baseline) in the proportion of respondents agreeing with the statement.

Figure 43: Progress on overall changes in the Mental Health, Drug and Alcohol system



During the follow up consultations, most stakeholders suggested that the Commission had made reasonable 'in-roads' over the last year into achieving some tangible impacts and this was seen as *"commendable"*. Most frequently, stakeholders referred to specific initiatives (e.g. review of the Mental Health Act, work with QLD Police to improve interaction with people with MH illness, grant funding) as evidence for this progress. However, while the majority of stakeholders were comfortable that "*things are starting to change*", they also highlighted that evidence of "*larger reform*" (e.g. formal arrangements (and accountability) for better working between cross-sectoral government departments and NGOs, broader ownership of MH and AOD as cross-sectoral issues) is still sparse.

> *"I believe that the commission is undertaking some real and relevant issues. Given time and funding they will with help make real changes"*
>
> - *2015 Survey respondent*

These sentiments were largely consistent with the free-text comments in the survey, and may be expected given the relative immaturity of the Commission as an organisation. Also, the more substantial elements of reform and 'structural change' to support collaboration (e.g. shared risks and resources, high levels of trust, altering of

activities) are known to require considerable time to achieve[18]. Encouragingly, the 2015 survey results highlighted that most stakeholders have opinions (Figure 33) that are supportive of the need for time to achieve wider impacts.

4.5.2 Summary

The Commission commenced many initiatives during the 2014/15 period that will contribute to the achievement of Collective Impacts for the mental health, drug and alcohol sectors and that are aligned to the evaluation questions in this domain. However, given the state, or recency, of completion of these initiatives it may be too early to measure their impact (particularly the sustainability of any anticipated impact), let alone the extent of the Commission's contribution. The development of a set of indicators (underway) to measure progress towards achieving the Strategic Plan's outcomes will provide a foundation against which to understand Collective Impacts in the coming years.

The survey results do however provide some promising interim results in that improvements were observed for all the high-level indicators of change in the mental health, drug and alcohol system.

4.5.3 Recommendations

Recommendation 16: Continue to progress and complete planned initiatives and collect data to allow the key evaluation questions in this domain to be answered in Stage 3 of the QMHC evaluation.

Recommendation 17: Ensure the performance indicators being designed to assess progress of the Strategic Plan implementation enable measurement of the Collective Impacts achieved.

Recommendation 18: Ensure the Commission continues to collect information relevant to identifying, justifying and communicating its contribution to the achievement of Collective Impacts for the mental health, drug and alcohol sectors.

[18] Leach, W., Pelkey, N., & Sabatier, P., (2002). Stakeholder partnerships as collaborative policymaking: Evaluation criteria applied to watershed management in California and Washington. *Journal of Policy Analysis and Management, 21*, 645-670.

5. Next Steps

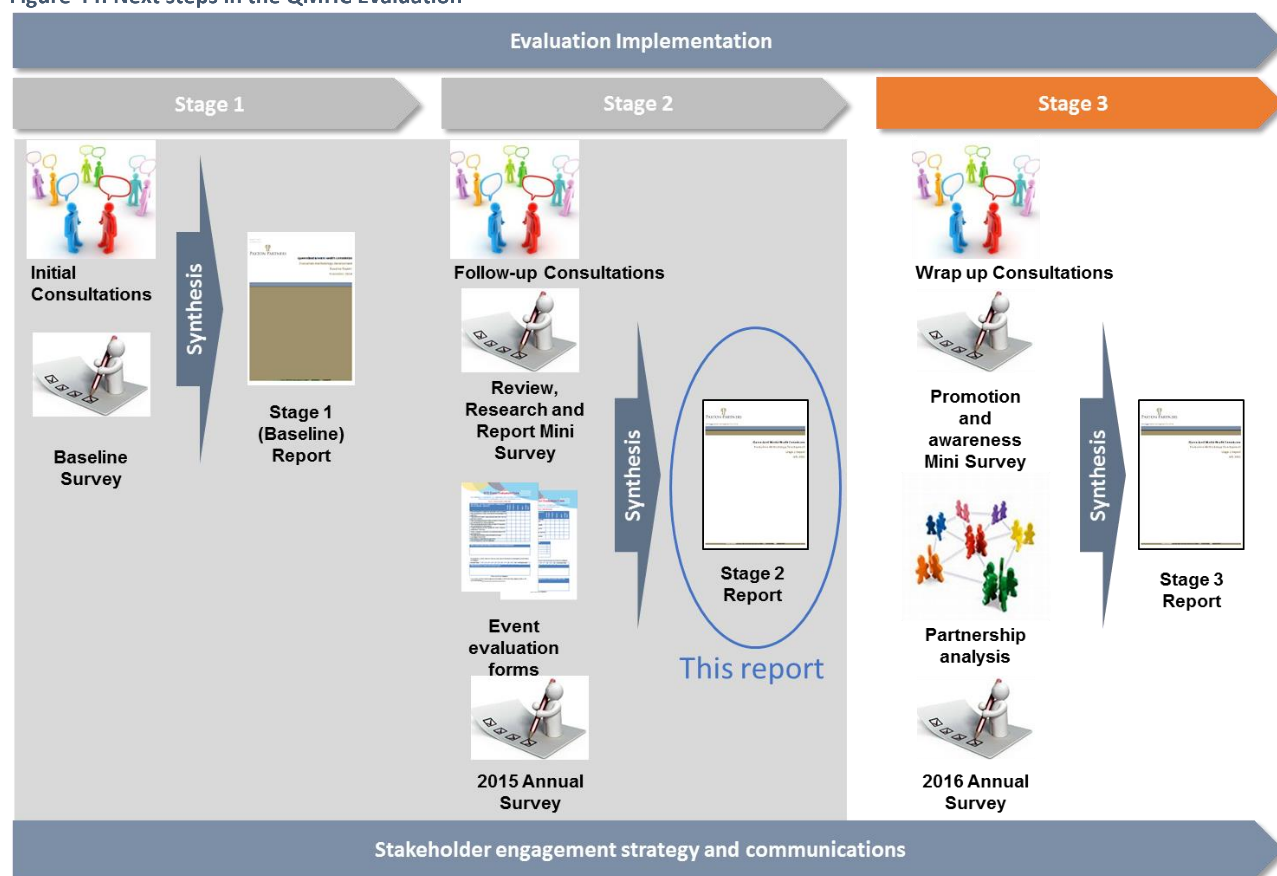
Figure 44 provides an overview of the activities of Stage 3 of the QMHC Evaluation, to be completed in the 2015/16 period. The focus of Stage 3 will be on assessing the Commission's effectiveness in facilitating the formation of sustainable cross sector collaborations to achieve the objectives of the Strategic Plan.

This is one of the key roles of the Commission, but its focused assessment (via a Partnership Analysis) was left to the final stage of the evaluation due to it being the area that requires the most time to observe change in (even the three year timeframe proposed may be too short to identify measurable change in this area).

In addition, we will undertake a targeted assessment of the Commission's Promotion and Awareness KRA, being the KRA with the largest budget allocation, but also the most related initiatives.

Finally, Stage 3 will include administration of the 2016 annual survey and development of the Stage 3 Report that will analyse and discuss the overall progress made by the Commission against the QMHC Evaluation Framework.

Figure 44: Next steps in the QMHC Evaluation



Appendix A – 2015 Survey questions

QMHC Evaluation Annual Survey - 2015

Introduction to the Queensland Mental Health Commission Evaluation Annual Survey

Informed Consent

What is this about?
This survey is part of a multi-year evaluation of the Queensland Mental Health Commission (QMHC). Its purpose is to explore stakeholder views on the QMHC's ongoing progress. The survey will be repeated as the evaluation progresses, to identify any changes over time in stakeholder views.

This is the second annual survey. The QMHC actions arising in response to the first baseline survey are on their website.

Why is this important?
Your input will assist in identifying both the key benefits and achievements of the QMHC, and any areas for improvement. The results of the survey will also inform the next steps in the overall QMHC Evaluation.

What do I have to do?
We hope that you will take approximately 10-15 minutes to complete this survey and submit your responses.

Is it confidential?
Yes, the survey is confidential. Only aggregated information will be used and your answers will not be linked to you personally.

Is participation voluntary?
Yes. Participation in this, and any subsequent QMHC Evaluation surveys, is completely voluntary. You can answer some, all or no questions. You can withdraw at any time. If you choose to withdraw, please contact Ms Anna Wilkins, Office Manager, at Paxton Partners (annawilkins@paxtonpartners.com.au).

*** 1. Do you agree to participate?**

○ Yes ○ No

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Anonymous ID

The use of an anonymous ID will enable us to identify changes to the question responses over the evaluation period. To protect your identity, while also enabling us to track how your views on the QMHC may change over time, we ask that you provide the following to create your anonymous ID.

*** 2. The first two letters of town in which you were born**

Letters (e.g. MA) [ ]

*** 3. The day of the month you were born**

Two digits (e.g. 08) [ ]

*** 4. The first two letters of the first school you attended**

Letters (e.g. KU) [ ]

For example, MA08KU (Maroochydore, 8th, Kuluin Primary School)

Understanding of the QMHC

An important part of this survey is to understand respondents' level of knowledge and awareness of the QMHC and the mental health, drug and alcohol system in Queensland.

5. To what degree are you familiar with the QMHC and the work that it does?

Not at all	Slightly	Moderately	Very
○	○	○	○

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Understanding of the QMHC

*** 6. Please rate your agreement or disagreement with the following statements:**

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I am interested to know more about the work of the QMHC.	○	○	○	○	○
I feel knowledgeable about the mental health, drug and alcohol system in QLD.	○	○	○	○	○

QMHC Evaluation Annual Survey - 2015

Understanding of the QMHC

*** 7. Please rate your agreement or disagreement with the following statements:**

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I understand the role of the QMHC.	◯	◯	◯	◯	◯
I understand the relationship between the work of the QMHC and my work/life.	◯	◯	◯	◯	◯
I am interested to know more about the work of the QMHC.	◯	◯	◯	◯	◯
I view the QMHC as an important driver of reform of the mental health, drug and alcohol system in QLD.	◯	◯	◯	◯	◯
I feel knowledgeable about the mental health, drug and alcohol system in QLD.	◯	◯	◯	◯	◯

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Understanding of the QMHC

The QMHC does not control funding for mental health, drug and alcohol services in Queensland.

8. Please rate your agreement or disagreement with the following statement:

	Strongly Disagree	Disagree	Agree	Strongly Agree	Unable to comment
The QMHC should control funding for QLD mental health, drug and alcohol services.	○	○	○	○	○

It is intended that the QMHC will provide strong and independent leadership and advocacy to ensure that maximising the mental health and wellbeing of all Queenslanders is recognised among the state's most critical challenges.

9. Please rate your agreement or disagreement with the following statements:

	Strongly Disagree	Disagree	Agree	Strongly Agree	Unable to comment
The QMHC is operating independently of Government.	○	○	○	○	○
The QMHC is operating independently of Queensland Health and other government agencies.	○	○	○	○	○

QMHC Collaboration and Consultation

Reforming the mental health and substance misuse system requires cross-sectoral effort. To support ongoing reform, the QMHC aims to promote and foster effective collaborations within and across sectors.

10. Please indicate all forms of contact/interaction you have had with the QMHC (select all that apply):

- ☐ No contact
- ☐ Mail/email contact
- ☐ Twitter
- ☐ Website
- ☐ Newsletter
- ☐ Forum attendance
- ☐ QMHC reports
- ☐ Press releases, media coverage
- ☐ Participated in meetings or workshops convened by the QMHC
- ☐ Member of a formal QMHC working party/committee
- ☐ Worked on a joint project/initiative with the QMHC

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QMHC Collaboration and Consultation

11. Please rate your agreement or disagreement with the following statements:

	Strongly Disagree	Disagree	Agree	Strongly Agree	Unable to comment
I understand how I impact the QMHC through my work.	○	○	○	○	○
I understand how the QMHC work impacts my work.	○	○	○	○	○
I believe there is a high level of awareness of the QMHC.	○	○	○	○	○
I believe the QMHC has demonstrated a sound understanding of the mental health, drug and alcohol issues in QLD.	○	○	○	○	○
I believe the QMHC is seen as a credible organisation.	○	○	○	○	○
I have had sufficient opportunities to provide input into QMHC work.	○	○	○	○	○
I or my organisation will benefit from the work of the QMHC.	○	○	○	○	○
I believe that people with mental health and/or substance misuse issues are benefitting from the QMHC's work.	○	○	○	○	○

QMHC Collaboration and Consultation

12. Please indicate your level of agreement or disagreement with the following statements:

	Strongly Disagree	Disagree	Agree	Strongly Agree	Unable to comment
The QMHC is engaging key stakeholders in appropriate, collaborative and meaningful ways.	◯	◯	◯	◯	◯
The QMHC is engaging the full range of relevant stakeholders.	◯	◯	◯	◯	◯
The QMHC is helping to improve collaboration within the mental health, drug and alcohol sectors.	◯	◯	◯	◯	◯
The QMHC is helping to improve collaboration across sectors (e.g. between health and justice, education, community etc).	◯	◯	◯	◯	◯

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About the Queensland Mental Health, Drug and Alcohol Strategic Plan

13. To what degree are you familiar with the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-19,* released by the QMHC in October 2014?

Not familiar	Heard about	Received document, but have not read it	Received and read document	Was part of working group to develop the document
○	○	○	○	○

QMHC Evaluation Annual Survey - 2015

About the Queensland Mental Health, Drug and Alcohol Strategic Plan

14. To what degree do you believe that the Queensland Mental Health, Drug and Alcohol Strategic Plan:

	Not at all	To some extent	To a large extent	Explicitly
Articulates a clear direction for addressing the needs of people in Queensland with mental health issues	○	○	○	○
Articulates a clear direction for addressing the needs of people in Queensland with substance misuse issues	○	○	○	○

About the Queensland Mental Health, Drug and Alcohol Strategic Plan

15. Please rate your agreement or disagreement with the following statements:

	Strongly Disagree	Disagree	Agree	Strongly Agree	Unable to comment
In the last eight months, I had adequate opportunity to contribute to the work arising from the Strategic Plan.	○	○	○	○	○
The Strategic Plan has influenced activities and decisions made within my organisation.	○	○	○	○	○
I or my organisation will participate in implementing the Strategic Plan.	○	○	○	○	○
The Shared Commitments to Action described in the Strategic Plan are appropriate and comprehensive.	○	○	○	○	○
The Strategic Plan identifies priorities that are important to me.	○	○	○	○	○

QMHC Evaluation Annual Survey - 2015

About the Queensland Mental Health, Drug and Alcohol Strategic Plan

16. Please indicate the extent to which you expect the Strategic Plan to influence:

	Too early to tell	Will not change	May change in the future	Very likely to change in the future	Has already influenced change
Benefits for consumers of mental health services and their families and carers	○	○	○	○	○
Benefits for consumers of drug and alcohol services and their families and carers	○	○	○	○	○
Collaboration between different providers of mental health services	○	○	○	○	○
Collaboration between different providers of drug and alcohol services	○	○	○	○	○
Collaboration between sectors (e.g. health, justice, housing, education, community services)	○	○	○	○	○
Collaboration between different levels of Government	○	○	○	○	○
Policies related to mental health and substance misuse	○	○	○	○	○
Decision making at the local service level	○	○	○	○	○
Decision making at the Government level	○	○	○	○	○

QMHC Evaluation Annual Survey - 2015

About the Queensland Mental Health, Drug and Alcohol Strategic Plan

17. In your opinion, how long do you think it may take to observe wider impacts in the mental health, drug and alcohol sectors as a result of the Strategic Plan?

- 1-2 years
- 3-5 years
- 5+ years

QMHC Evaluation Annual Survey - 2015

QMHC Activity

18. Please rate your agreement or disagreement with the following statements:

	Strongly Disagree	Disagree	Agree	Strongly Agree	Unable to comment
The research, review and evaluation work the QMHC is commissioning helps identify and respond to current and emerging issues and trends.	○	○	○	○	○
The promotion and awareness work being undertaken by the QMHC is increasing community awareness and reducing stigma and discrimination.	○	○	○	○	○
The Queensland Mental Health and Drug Advisory Council is providing effective advice to drive appropriate reform.	○	○	○	○	○
The QMHC is utilising the views of people with lived experience, their families, carers and support people to inform planning and decision making.	○	○	○	○	○
The reforms the QMHC is driving will be sustainable over the long term.	○	○	○	○	○

QMHC Evaluation Annual Survey - 2015

Overall Mental Health, Drug and Alcohol System Impact

The QMHC is aiming to drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system. Achieving this goal requires the input, support and work of many players.

19. Thinking about changes at an overall system level since 2013, please rate your agreement or disagreement with the following statements:

	Strongly Disagree	Disagree	Agree	Strongly Agree	Unable to comment
Overall, there is positive reform underway.	○	○	○	○	○
Effective promotion, prevention and early intervention initiatives are increasing.	○	○	○	○	○
Mental health, drug and alcohol services are improving.	○	○	○	○	○
Accountability and transparency is improving.	○	○	○	○	○
There is ongoing and sustainable change being created by and within the mental health, drug and alcohol sectors.	○	○	○	○	○

QMHC Evaluation Annual Survey - 2015

QMHC Successes and Suggestions

20. In what ways is the QMHC working well?

21. In what areas is the QMHC not working well?

22. Do you have any suggestions for what the QMHC could do to better drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system?

QMHC Evaluation Annual Survey - 2015

About You

This section provides us with important information about you that allows us to categorise the survey results. Please take the time to complete the following questions. Your responses will remain anonymous.

*** 23. Please select the options that best describe your roles (select all that apply):**

- [ ] Person with lived experience of mental health and/or substance misuse issues
- [ ] Family member of a person with lived experience
- [ ] Caregiver of a person with lived experience
- [ ] Advocacy/ Peak Body employee or representative
- [ ] Service provider employee or representative
- [ ] Non-government Organisation representative
- [ ] Researcher
- [ ] Teacher
- [ ] Government Employee
- [ ] QLD Mental Health and Drug Advisory Council Member
- [ ] Media representative
- [ ] University academic
- [ ] International partner
- [ ] Politician or political advisor
- [ ] Other (please specify)

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About You

24. Please indicate your current role.

- Board/Executive
- Frontline
- Management
- Not Applicable
- Administration
- Other (please specify)

QMHC Evaluation Annual Survey - 2015

About You

*** 25. Please indicate the sector/s in which you work or represent (select all that apply):**

- [ ] Mental Health
- [ ] Health
- [ ] Employment
- [ ] Education
- [ ] Child and Family
- [ ] Police
- [ ] Drug and Alcohol
- [ ] Housing
- [ ] Justice
- [ ] Community
- [ ] Business or Private
- [ ] Other (please specify)

QMHC Evaluation Annual Survey - 2015

About You

26. Please indicate whether you identify as a member of one or more of the following groups (select all that apply):

- ☐ Aboriginal and/or Torres Strait Islander background
- ☐ Culturally and linguistically diverse
- ☐ Person with a disability
- ☐ Person experiencing both mental health difficulties and issues related to substance use
- ☐ Lesbian, gay, bisexual, transgender or intersex

27. Please indicate your gender

- ○ Male
- ○ Female
- ○ Transgender or intersex

28. Please indicate your age group

- ○ Less than 18 years old
- ○ 18 to 24 years old
- ○ 25 to 44 years old
- ○ 45 to 64 years old
- ○ 65 years and older

*** 29. Please indicate your postcode**

Postcode ____________________

QMHC Evaluation Annual Survey - 2015

Final comments

30. Is there anything else you would like to let us know?

Appendix B – Survey Design Flowchart