PAXTON PARTNERS

Queensland Mental Health Commission

Evaluation Methodology Development

Final Stage 3 Report

September 2016

Including QMHC management comment

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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 the evaluator's and the QMHC's prior written consent.

The report includes references to the views of various QMHC stakeholders. The evaluator 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, the evaluator 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

The evaluators 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 was critical to the evaluation and improvement of the QMHC to what should ultimately be to the benefit of Queenslanders impacted by mental health issues, suicide and attempted suicide or harms associated with alcohol and other drugs.

1. Executive Summary

1.1 Summary of key findings

Since its first year of inception (2013/14) the Commission has built a strong foundation and managed to 'move the dial' on a range of metrics key to the performance of its role as a 'backbone organisation' and collaborative capacity builder.

The 2015/16 year has seen a distinct and appropriate shift in the Commission's focus towards support for implementation of the Strategic Plan, developed during its second year of operations. This shift has entailed not only an increase in development and release of key action plans underpinning a number of the shared commitments defined in the Strategic Plan, but also an apparent increase in the breadth of its engagement outside of 'core' mental health organisations.

While still too early to measure the impact from the action plans, it is encouraging that a growing majority of stakeholders saw the promotion and awareness activities undertaken by the QMHC as increasing community awareness and reducing stigma and discrimination. It will be critical to measure the stakeholder perceptions and impacts from these actions plans and the others scheduled for release in the coming year. Notably, in the most recent survey, the majority of stakeholders now believe that the wider impacts of the Strategic Plan will take more than five years to be observed. This suggests, perhaps, a greater appreciation for the effort and initiatives required to make the changes needed to benefit Queenslanders.

Key to achieving the Shared Commitments to Action defined in the Strategic Plan will be strong collaboration amongst the various players in the mental health, drug and alcohol sectors. As a backbone organisation, the QMHC must work to facilitate not only strong collaboration between itself and others, but also between different organisations, to support sustainability of impacts.

In the previous evaluation years, it was too early to measure significant change in collaboration. However, the 2015/16 year had a specific focus on measuring the strength of collaboration between the QMHC, government departments and other organisations and between organisations.

The majority of respondents reported that their organisation had no/low level of current collaboration with the QMHC and that this was not sufficient to achieve their current strategic goals. However, a third reported mid-high level of collaboration with the QMHC and that this was sufficient to achieve their current strategic goals. A particular group that requires more focus from the QMHC is HHSs, who have consistently reported low engagement with the QMHC. An increasing proportion of respondents in each survey year reported that the QMHC is helping to improve collaboration within the mental health, drug and alcohol sectors, with the largest improvement seen for AOD stakeholders in the 2016 year.

Encouragingly, respondents from all sectors reported that collaboration between their organisation and the QMHC will be essential to achieving their future strategic goals, irrespective of the current levels of perceived collaboration.

It is not necessary for the QMHC to be at a high level of collaboration with every stakeholder group (e.g. co-operating/co-ordinating may be sufficient in many cases). However, over the coming years, the QMHC must work to increase the number of stakeholders that are able to comment on the level of collaboration between their organisation and the QMHC and build on current relationships to move them towards an appropriate level of collaboration for their joint objectives.

Over the last three years the QMHC has increased the modes of engagement with its stakeholders, including implementing a continuously improving social media strategy. However, consistent across all evaluation years, the majority of stakeholders did not feel that there was a high level of awareness of the QMHC nor did they report that the QMHC is engaging the full range of relevant stakeholders. This suggests a need to continually look for new and innovative ways in which to identify key stakeholders and engage them in the QMHC's work.

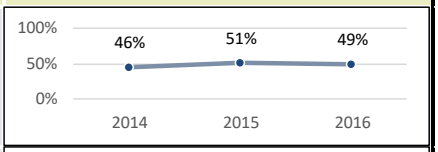
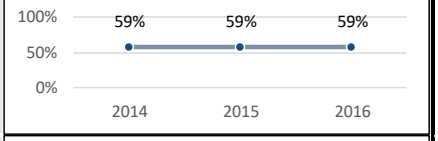
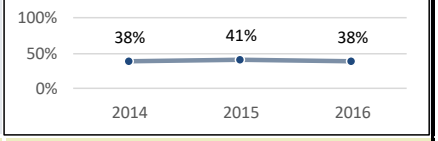
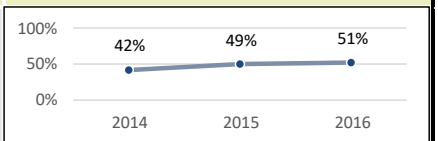
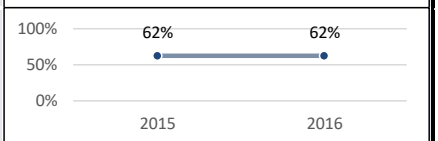
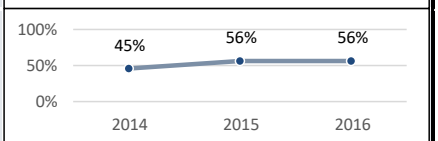
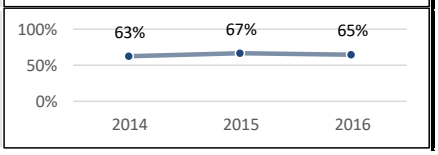
In terms of collective impacts, there has been an increase each year in the proportion of respondents that believe that overall there is positive reform underway in the Mental Health, Drug and Alcohol System. However, in terms

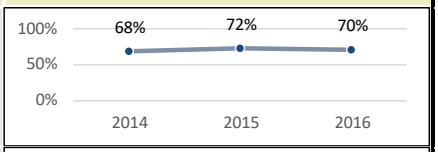
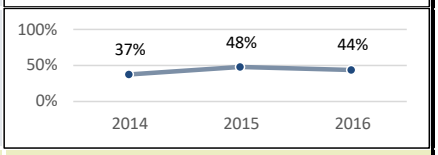
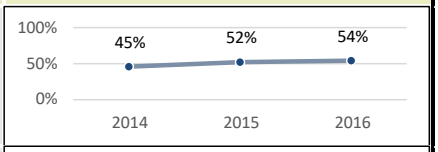
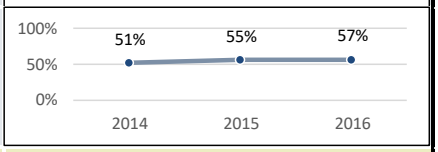
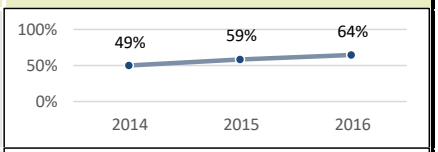
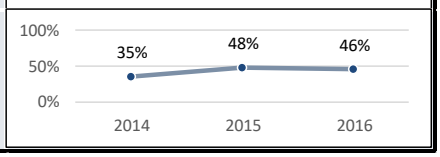
of the overall benefits for people with lived experience of mental health difficulties, alcohol and other drugs issues and people impacted by suicide, only a minority believed positive reform was underway. While these are the ultimate indicators of success for a high-performing mental health, drug and alcohol system, achieving benefits at these levels are likely to take a longer period of time.

These indicators were measured in their current form for the first time in the 2015/16 survey and should be monitored carefully over time to identify future impacts. The set of indicators identified by the QMHC in its first annual indicators report (released in 2015/16) will provide a foundation against which to understand Collective Impacts in the coming years.

1.2 Summary of key metrics

The following tables summarise the key metrics for the QMHC, some of which contribute to the QMHC's reported Service Delivery Standards (SDSs). The QMHC should continue to measure and report on these metrics to monitor continued progress over time.

Key Metrics	Percent Total Agree
Stakeholder satisfaction	
Stakeholders have sufficient opportunity to provide input	
The views of consumers, families and carers inform QMHC work	
The full range of stakeholders is being engaged	
QMHC functions	
QMHC is building collaboration across sectors	
The Strategic Plan priorities are important	
QMHC is increasing community awareness of mental health	
QMHC research, review, report work is relevant	

Key Metrics	Percent Total Agree
Credibility	
Commission is credible	
The Advisory Council provides effective advice	
Independence	
QMHC is independent of Government	
QMHC is independent of Queensland health and other government agencies	
Mental Health and Drug and Alcohol Reform Progress	
Positive reform is underway	
Reforms are sustainable	

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 (2015/16 period) in addressing the recommendations of the Baseline Report (2014) and Stage 2 Report (2015) and more broadly progress with respect to the key evaluation metrics. 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.

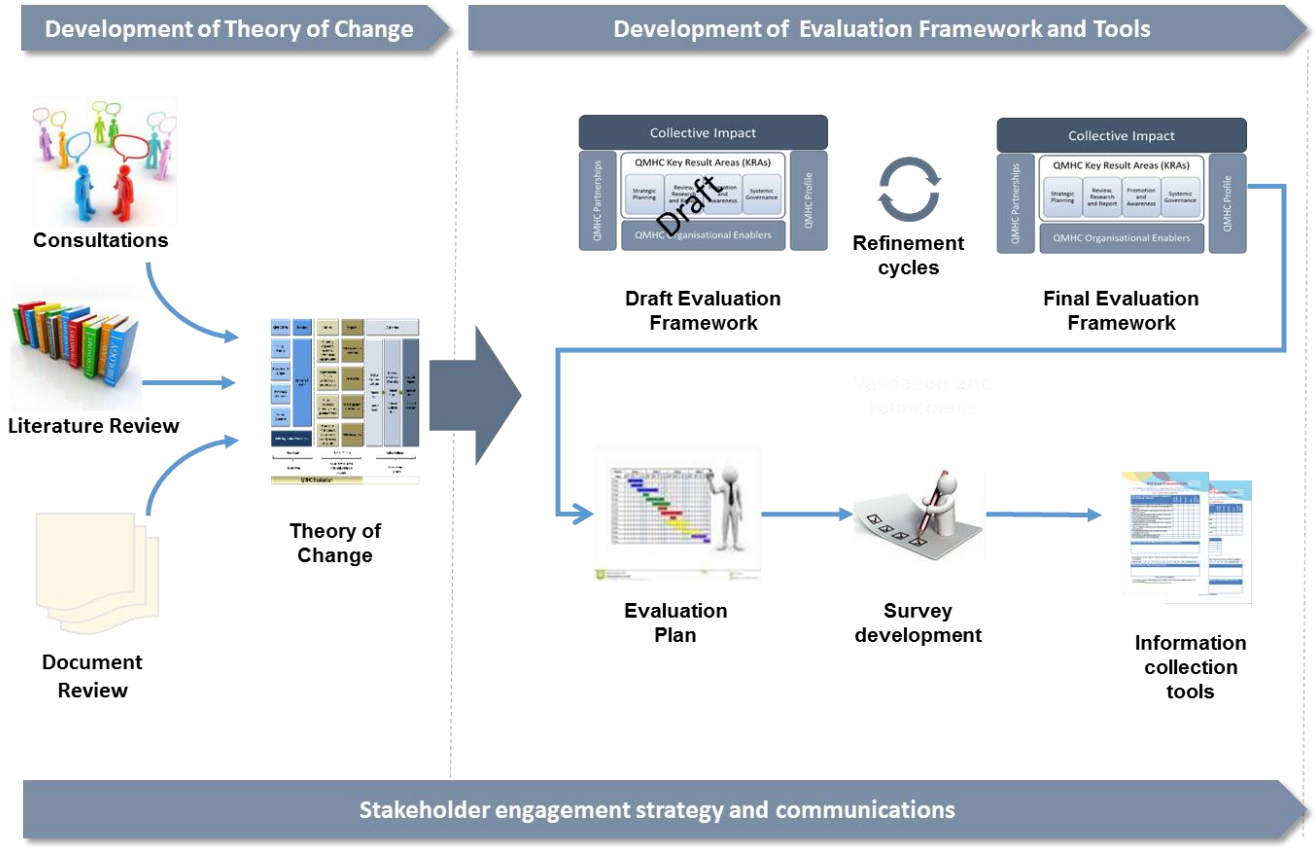
The report draws from the data sources described in Section 3 and provides a series of observations for the Commission to consider in entering the 2016/17 period.

As the final report in this series of evaluation activities, boxes such as this are included throughout, outlining "Management Comments" from the QMHC in response to specific survey findings.

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

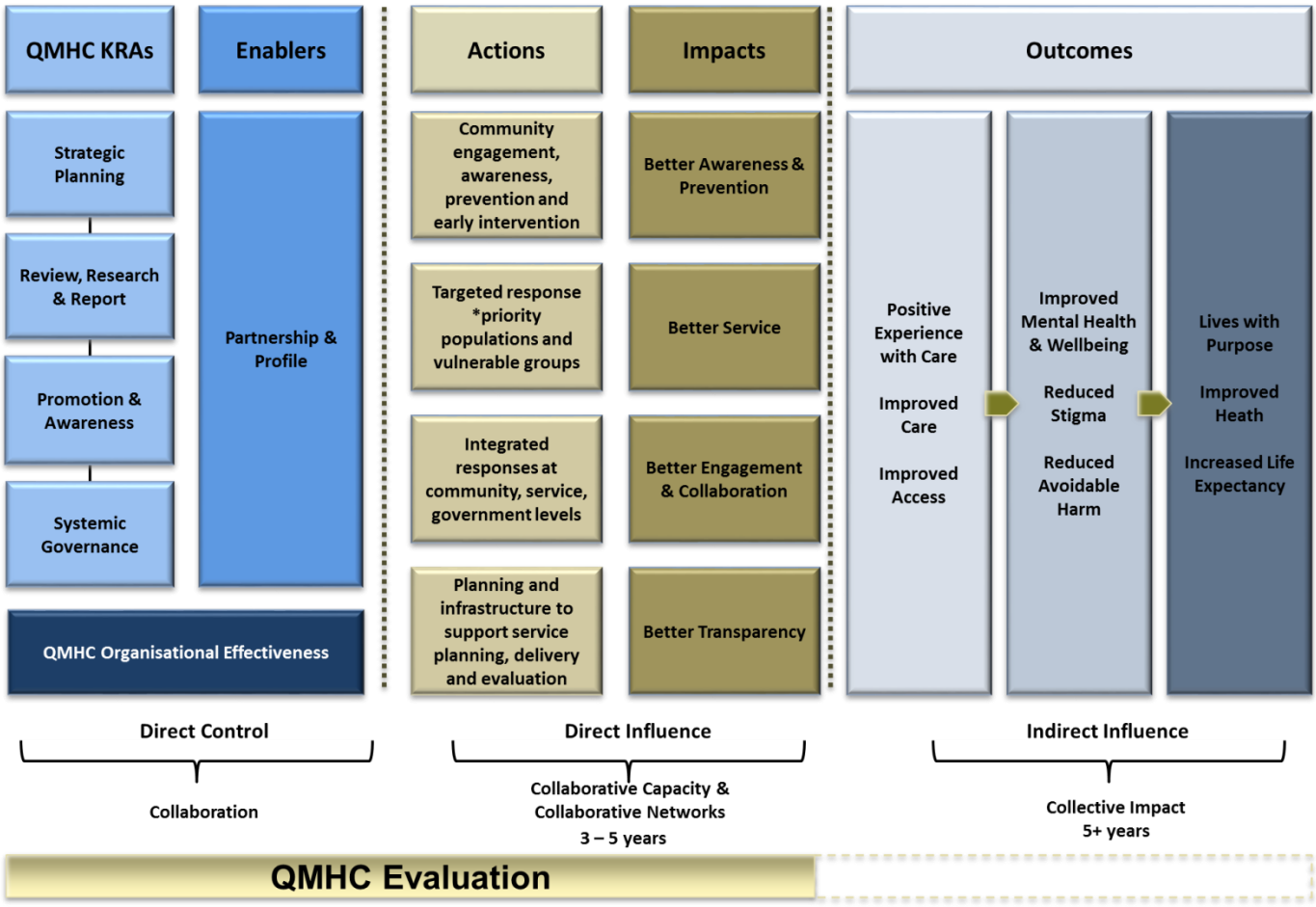


[1] The full Literature Review is available here: http://www.qmhc.qld.gov.au/about-us/our-performance/performance-framework/ , accessed 19 August 2015

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, Alcohol and Other Drugs 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

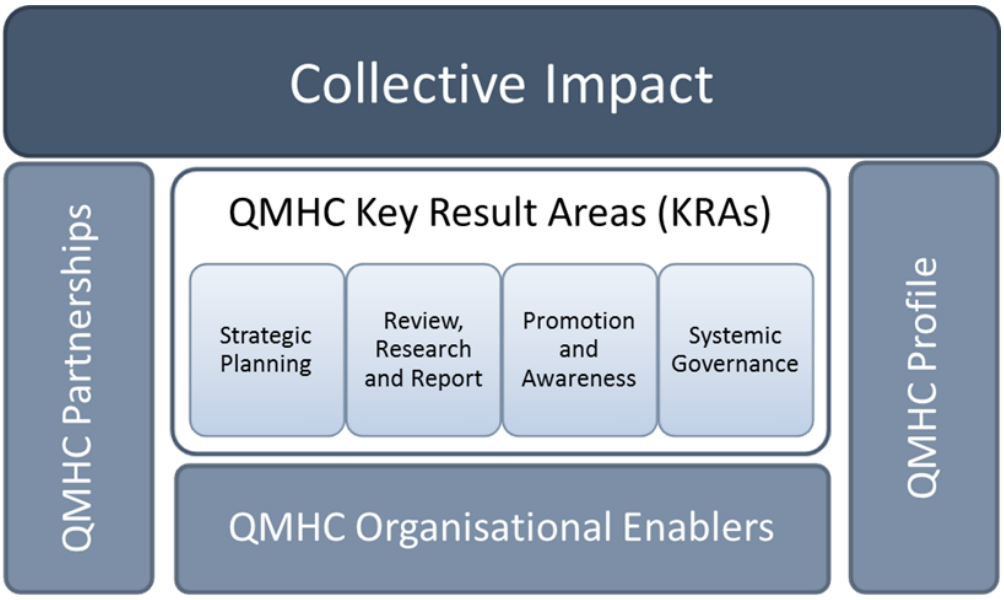
Key indicators of effectiveness	Example measures of success
Leveraged funding	Ability to catalyse, pool or redirect funding in support of the initiative's common agenda
Indicators of initiative progress	Initiative-level early indicators May be more output/process measures – e.g. number of organisations 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 success indicators 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 provides 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** explore 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.

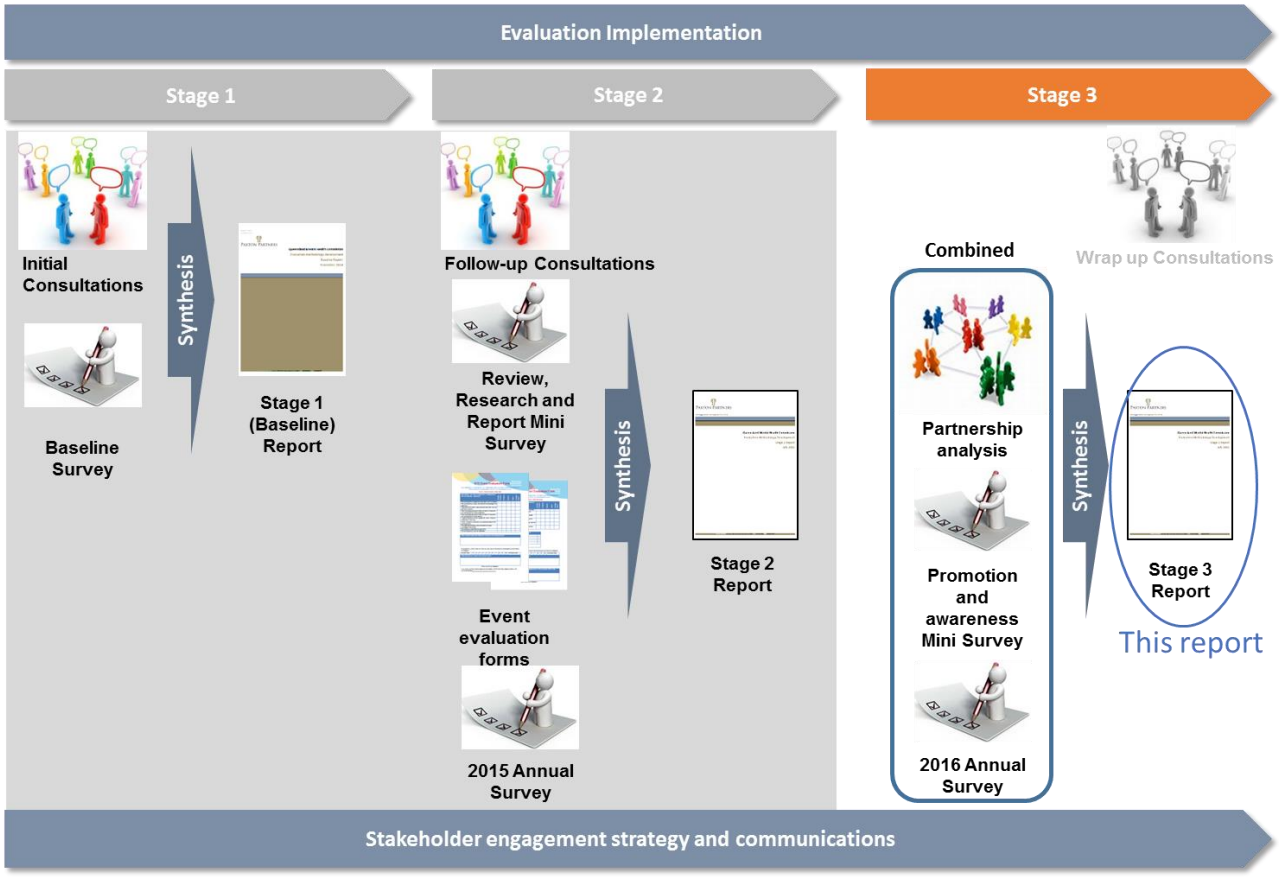
A series of specific evaluation questions (outlined in each sub-section in Section 4) support each of the key domains.

3. Evaluation activities to date

3.1 Overview

Implementation of the QMHC Evaluation was 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[4] (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)**: This stage sought to understand the QMHC's overall performance over its first three years of operation and progress towards the achievement of beneficial impacts for the mental health and wellbeing of Queenslanders. In particular, this stage included an attempt to assess the QMHC's impact on improving collaboration within the QLD Mental Health, Alcohol and Other Drugs sectors, and with other related sectors, as collaboration serves as a key mechanism to achieve collective impacts.



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

[4] Results from Stage 2 are reported in the QMHC Final Stage 2 Report available here: https://www.qmhc.qld.gov.au/wp-content/uploads/2016/05/QMHC-Evaluation-Final-Stage-2-Report.pdf, accessed 27 July 2016

This report focuses on the presentation of results from Stage 3 (final stage) of the evaluation, and where relevant, comparisons with the previous Stage 2 (2015) and Baseline (2014) Reports. The sub-sections below present a high-level synthesis of the evaluation activities undertaken to date.

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, alcohol and other drugs 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*[5] 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, alcohol and other drugs sectors that have been influenced by the QMHC.

3.2.3 Wrap up consultations (Stage 3)

The end of Stage 3 of the evaluation overlapped with the Queensland Public Service Commission's (PSC) independent review, which also included targeted consultation activities with QMHC stakeholders. As a result, it was decided that the QMHC would leverage the stakeholder feedback from the PSC's process independently of the evaluation process, rather than engaging the same people within a similar timeframe and risking consultation fatigue.

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

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 every year to stakeholders that have engaged with the QMHC in the preceding year. The survey therefore captures a mixture of new respondents as well as those who completed preceding surveys.

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. The 2016 Survey (see Appendix A – 2016 Survey questions) included an additional set of questions dedicated to understanding stakeholder perceptions of the Commission's effectiveness at developing meaningful collaborations with a range of stakeholders and also the effectiveness of its Promotion and Awareness activities (in lieu of undertaking a separate Mini Survey on the topic as was initially planned).

In 2016, the evaluation survey was promoted by the PSC to contribute to the independent review it was running in parallel with the end of Stage 3 of the evaluation. As a result, a wider array of QLD State Government Employees was formally invited to respond and provided with a weblink to access the survey. This contributed to an increase in the overall respondent numbers and the breadth of government departments represented, including some respondents who may not have been previously aware of the Commission's activities.

While the total number of survey invitees has more than doubled since the Baseline Survey (Table 2), the overall survey response rate declined in 2015 and remained approximately the same for 2016.

Table 2: Summary of survey statistics

Survey Year	Response period	Total known invitees	Total Respondents	Approximate Response Rate[6]
Baseline (2014)	24 Aug – 16 Sep 2014	1667	581	35%
2015	1-23 June 2015	2390	590	25%
2016	11 May – 8 June 2016	3587	854	24%

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.

The sub-section below presents a comparison of the profiles of survey respondents between the Baseline Survey, the 2015 Survey and the 2016 Survey.

3.3.1.1 Profile of Survey Respondents

Of the survey respondents that provided a valid postcode (~70-80% of total respondents), the majority (96-98%) of those providing a valid postcode indicated as being in Queensland.

Figure 4 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, while Major Cities is over-represented. The

[6] It was not possible to track how many people were invited to complete the survey via the web-link, Facebook or Twitter and therefore the true number of potential respondents is understated, and by extension, the reported response rate represents an estimate only.

proportion of respondents from Major Cities is even higher in the 2016 year (67% of overall), likely due to an increase in the proportion of QLD State Government Employee respondents.

Figure 4: Survey respondents by remoteness

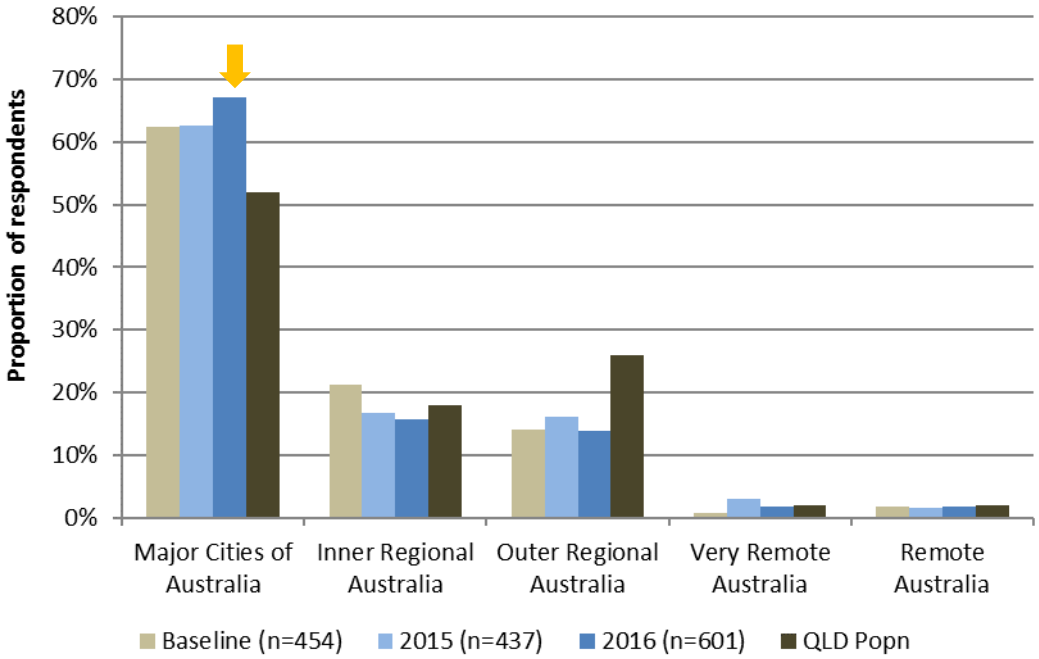
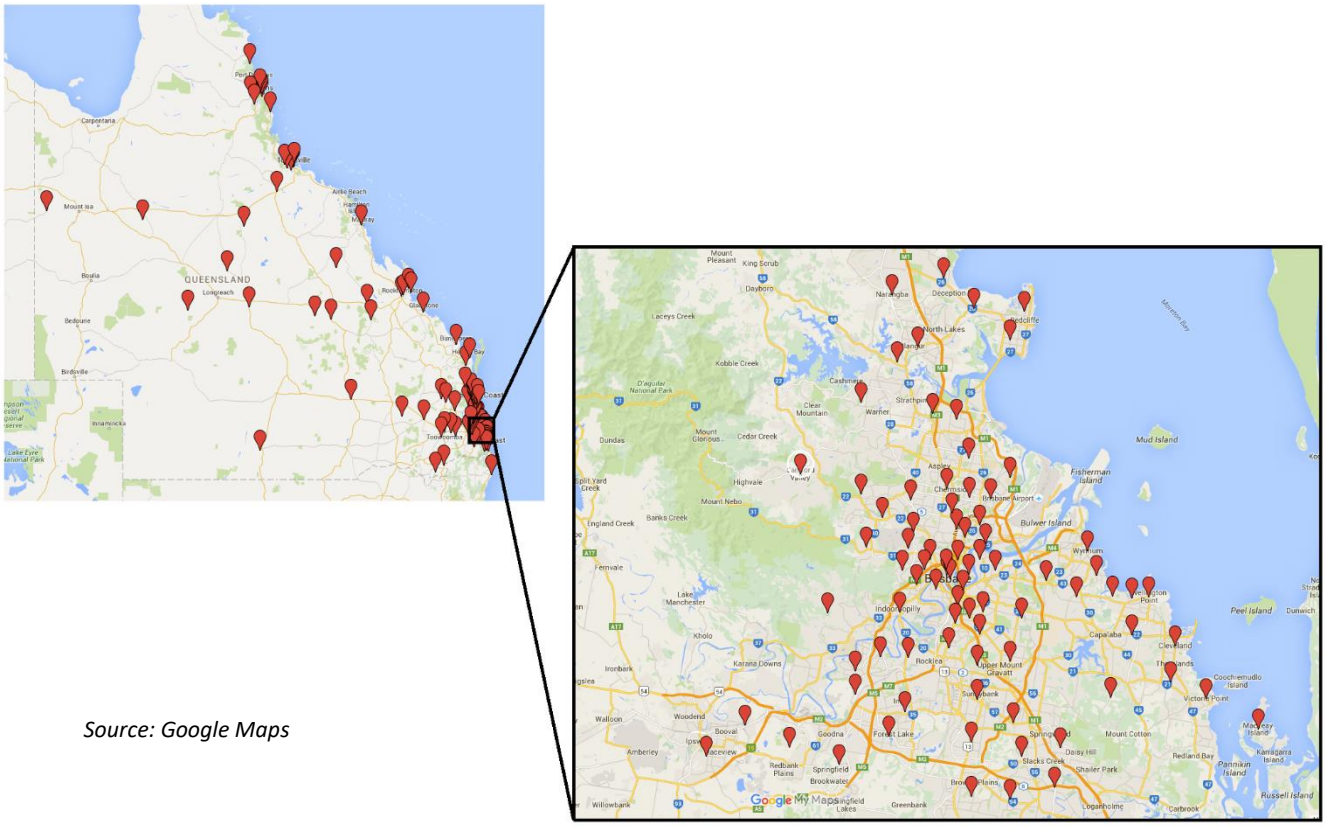


Figure 5 is a graphical map depicting the location of 2016 survey respondents by postcode. Consistent with previous years, the majority of respondents were clustered in Queensland, specifically around Brisbane.

Figure 5: Geographical mapping of respondents by postcode



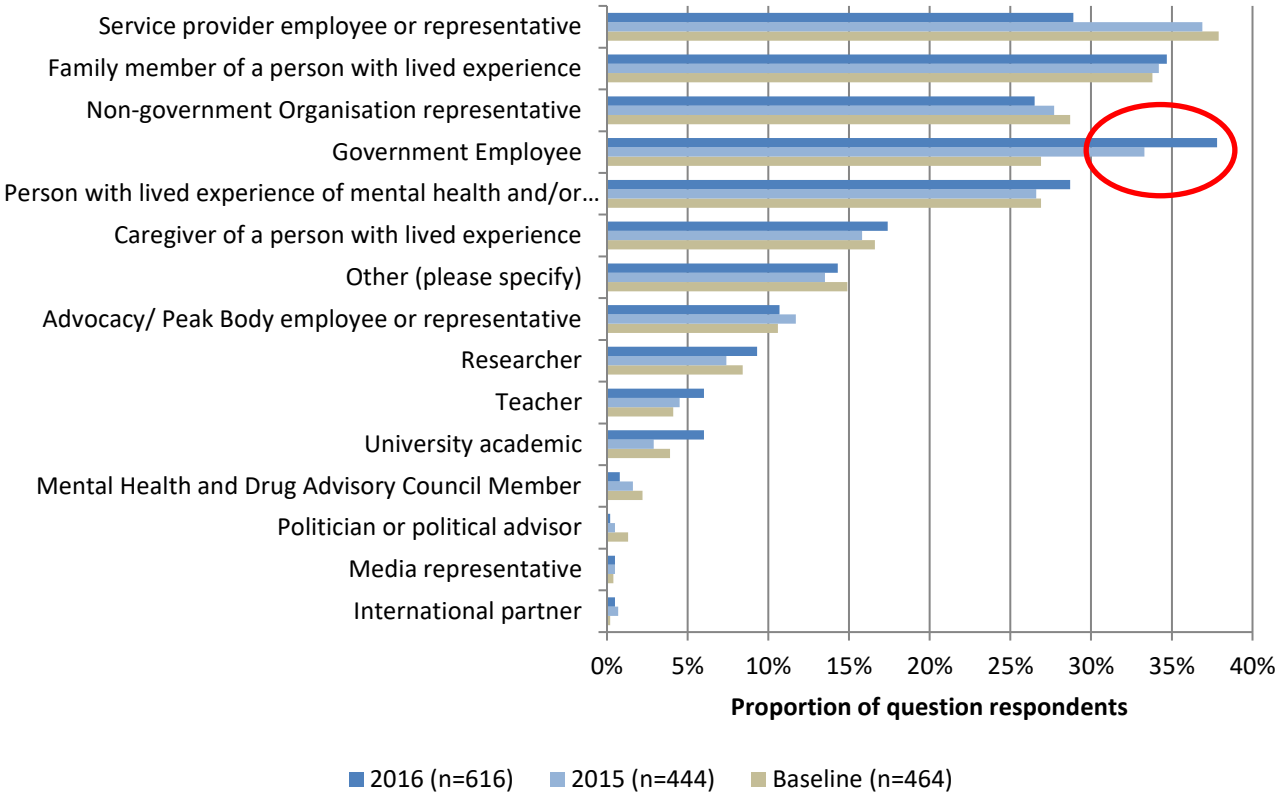
Source: Google Maps

Respondents represented a variety of personal roles in the community (Figure 6). The largest proportion of respondents in the 2016 year identified as Government employees. This was a shift compared to previous years where the proportion of employees or representatives of service providers was the highest followed by family members of a person with lived experience, Government employees and people with lived experience.

As identified above, the proportion of Government employee respondents was likely influenced by the promotional work undertaken by the PSC.

Similar to prior years, approximately, 15% of respondents identified as 'Other'. There was no trend amongst these respondents, which included clinicians, volunteers, mums, researchers, individual advocates, and representatives of small grass-roots organisations.

Figure 6: Personal role of survey respondents



A new demographic question was added in the 2016 year to explicitly identify the department of Queensland State Government Employees (Figure 7) to assist in assessing the awareness of the QMHC and its work across sectors and its effectiveness in building cross-sectoral partnerships.

The largest proportion of Queensland State Government respondents identified as being from Department of Health (including eHealth Queensland) (28%), followed by Hospital or Health Service (26%) and Queensland Police (15%). The next largest proportion (9%) was for 'other' departments, consisting of a mixture of departments each with less than 5 respondents (departments have not been listed to preserve the identity of respondents).

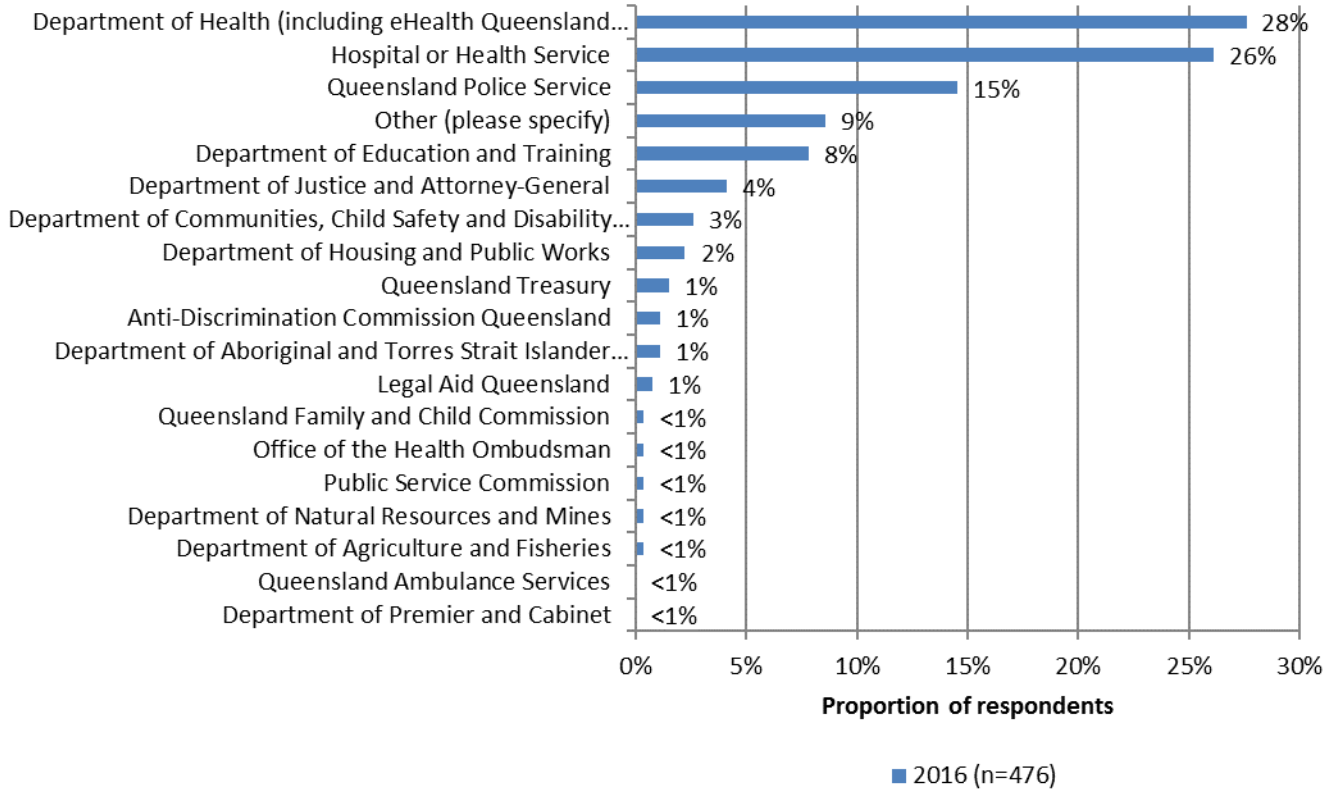
Areas QMHC doing well:

"Collaboration - being human, engaging community level and also individuals of organisations, not just CEO's"

- *2016 Survey respondent*

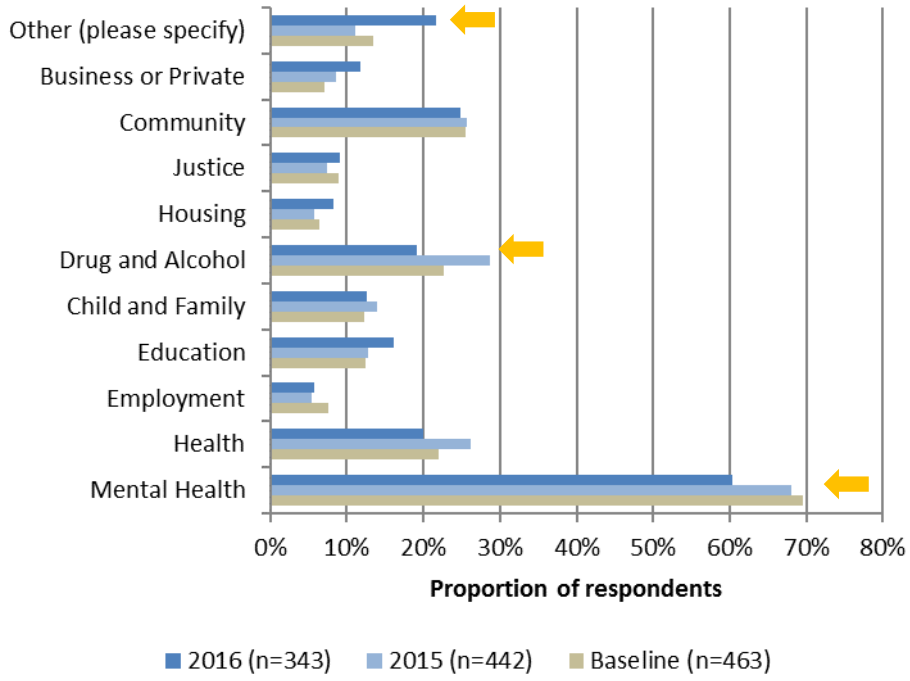
Respondents from Department of Education and Training made up 8% of the total Queensland State Government Employees, while the remaining departments all made up less than 5% of the total each.

Figure 7: Queensland State Government employee respondents – by area



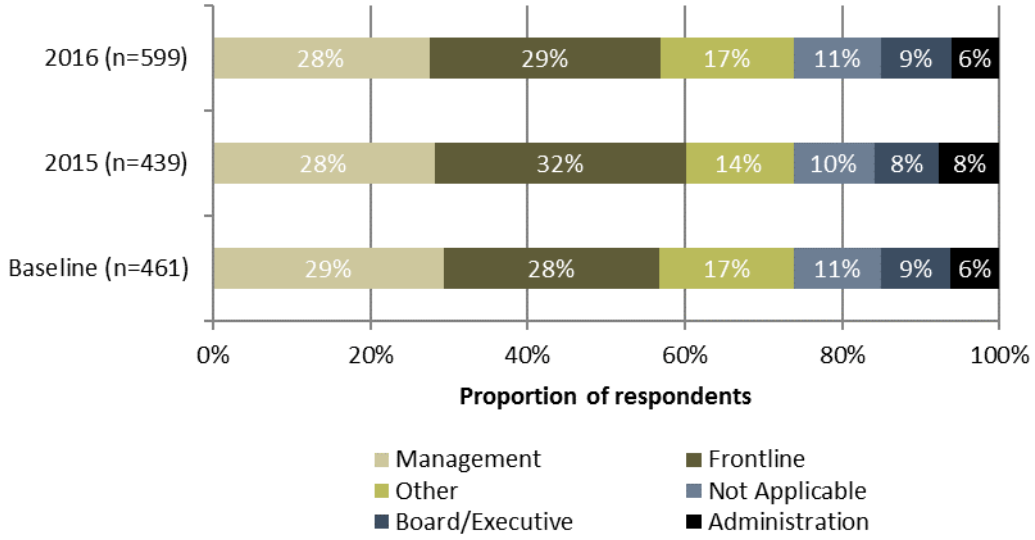
Most sectors within Queensland were represented in the survey results (Figure 8), although the Mental Health sector dominated, comprising ~60% of the 2016 respondents. This was approximately 10% lower than was observed for the Baseline and 2015 surveys, likely explained by a roughly equivalent increase in the proportion of respondents identifying their sector as 'other'. This suggests that respondents to the 2016 survey represented a wider mix of sectors than in previous years.

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. The mix of respondents by organisational position remained virtually unchanged across all three survey years. Management and Frontline staff were represented in almost equivalent proportions (~29%), whereas Board/Executive made up just under 10%, and Administration around 6%.

Figure 9: Positions of survey respondents



Approximately a quarter of all respondents to each survey identified as representing one or more priority populations. Table 3 presents the proportion of overall survey respondents, across all years, that identified with each priority population group, as compared to the indicative Queensland population rates, where available.

Table 3: Survey respondents representing priority populations[7]

Priority population groups	2014 (n=453)	2015 (n=433)	2016 (n= 597)	Indicative QLD population rates	Source
Aboriginal and/or Torres Strait Islander background (ATSI)	6%	8%	5%	3.6%	2011 Census QLD Figures
Culturally and linguistically diverse (CALD)	7%	6%	7%	20.5%	2011 Census QLD Figures
Person with a disability	9%	7%	8%	17.7%	2012 Survey Disability Ageing and Carers ABS
Person experiencing both mental health difficulties and issues related to substance use	6%	6%	8%	N/A	
Lesbian, gay, bisexual, transgender and intersex (LGBTI)	5%	6%	4%	N/A	

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

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

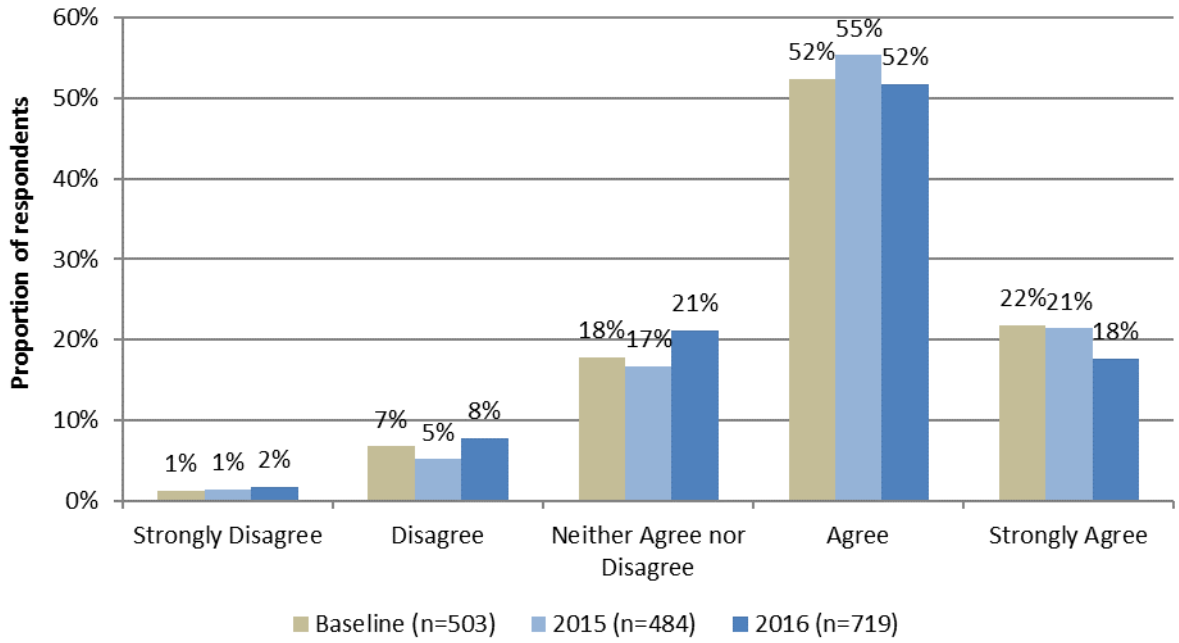
> *"Dual Disability [Intellectual Disability and Mental Illness] also Intellectual Disability and Addictions is a poorly resourced area."*
>
> - *2016 Survey respondent*

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

Important to the quality of the survey results, is respondents' perceived knowledge of the 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 all three 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. In the 2016 year, there was a slight increase in the proportion of respondents reporting "Neither Agree nor Disagree" (2016: 21% vs 2015: 17%) and a 6% decline in the total proportion that reported feeling knowledgeable about the mental health, drug and alcohol system in QLD.

Overall, this may suggest a slight shift in 2016 towards respondents who are less knowledgeable about the mental health, drug and alcohol system in QLD. However, this may not be surprising, considering that (per Figure 8) a lower overall proportion of respondents identified as being from either the mental health or alcohol and other drugs sectors. This may in turn be reflective of the wider distribution of the 2016 survey to stakeholders beyond representatives from health/mental health.

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



4. Evaluation results

This section describes the key findings from the evaluation activities against each of the evaluation domains. Each sub-section describes the key evaluation questions and a summary of the key evaluation findings. The findings are organised in line with the Theory of Change (Figure 2), beginning with those areas within the QMHC's direct control, direct influence, and indirect influence leading to collective impact.

4.1 QMHC Organisational Enablers

4.1.1 Key Findings

The Final Stage 2 Evaluation Report provided an overview of the evaluation findings on the QMHC's performance with respect to this evaluation domain, so it is not covered in detail here. In addition, the PSC review that was undertaken in parallel with Stage 3 had a specific focus on the performance of the QMHC against its key result areas.

4.1.2 Summary

Previous 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. The PSC report may provide further and recent assessment of the observed alignment of the QMHC's strategy and operations with the *Queensland Mental Health Commission Act*.

4.2 QMHC Partnerships

The Act requires the QMHC to facilitate the contribution of multiple stakeholders. This includes, in many cases, various Queensland government departments; reflecting the multiple, often complex, service needs of people experiencing mental illness and/or substance misuse issues.

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

Table 4 (adapted from Himmelmann[8]) outlines the progressive stages of maturity of collaboration. This framework provided a key reference point for the QMHC Evaluation Framework design. While collaboration is not always required for effective partnerships nor possible given the high resource demands and time for development, for many of the Commission's objectives, collaboration with multiple parties will be necessary to ensure sustainability.

Table 4: 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

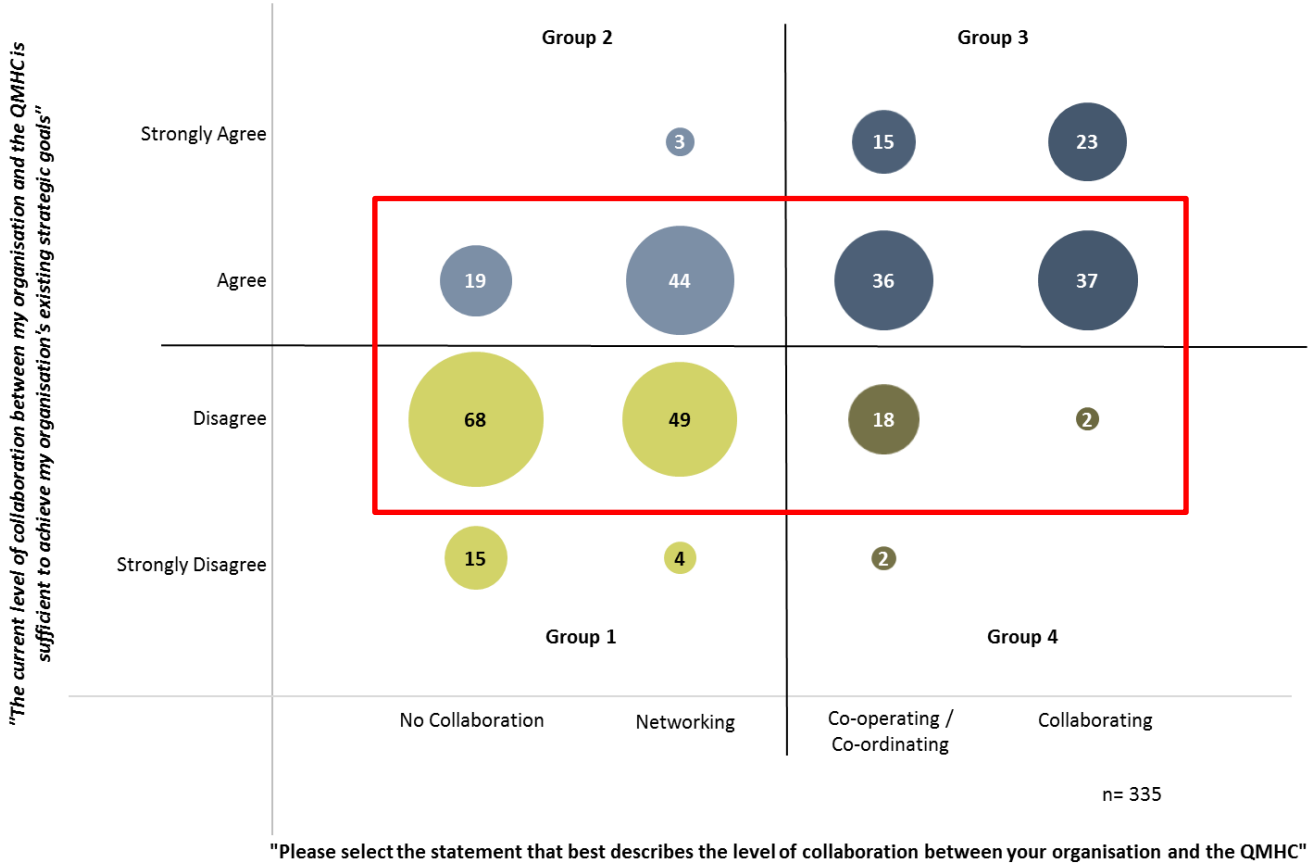
[8] Himmelman, A., (2001). On coalitions and the transformation of power relations: collaborative betterment and collaborative empowerment. *American Journal of Community Psychology, 29*, 277-284.

4.2.1 Key findings

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

Figure 11 plots the overall number of respondents according to their perception of the current level of collaboration between their organisation and the QMHC and the extent to which they agree that the current level of collaboration is sufficient to achieve their organisation's strategic goals.

Figure 11: Current perceived collaboration with the QMHC compared to whether collaboration is important for current goals



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

- **Group 1:** No/low level of collaboration and **don't agree** that this is sufficient (n=136, 41%)
- **Group 2:** No/low level of collaboration and **agree** that this is sufficient (n=66, 20%)
- **Group 3:** Mid-high level of collaboration and **agree** that this is sufficient (n=111, 33%)
- **Group 4:** Mid-high level of collaboration and **don't agree** this is sufficient (n=22, 6%)

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

Group 2 represent an interesting group in that these respondents (particularly those indicating their current level at "Networking"), appear content that this level of collaboration is sufficient to achieve their strategic goals. This is encouraging and supports the notion that a high degree of collaboration may not be required in all cases to achieve Collective Impact. Only a very small proportion (~6%) of respondents indicated that no collaboration with the QMHC is necessary to achieve their strategic goals.

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

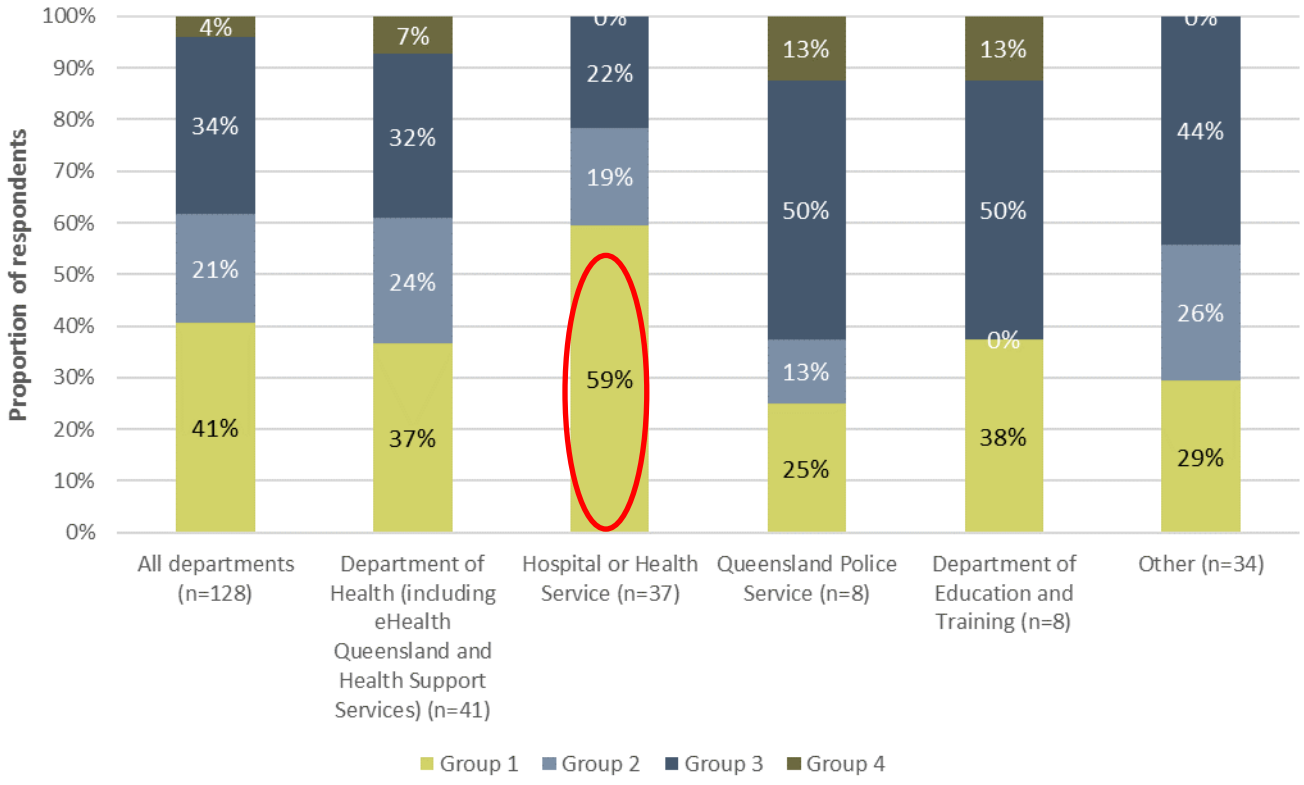
Overall, these results suggest that survey respondents view collaboration with the QMHC as key to achieving their strategic goals. This is further supported by the fact that the majority (67% overall) of respondents to Question 12b reported collaboration with the QMHC as being essential to achieving their organisation's future strategic goals, irrespective of current level of collaboration (data not shown).

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

For all respondents identifying as QLD government employees (n=128), over half fell into Groups 2 and 3 (per Figure 11), indicating they were comfortable with the current level of collaboration between their organisation and the QMHC. However, almost 60% of respondents identifying as employees of hospital or health services fell into Group 1 (e.g. not happy with current no/low level of collaboration), suggesting that there may be a need for the QMHC to improve collaboration with these key stakeholders.

This finding is consistent with stakeholder consultations undertaken for the Stage 1 (2014) and Stage 2 (2015) evaluation reports that suggested more engagement at the HHS level is required. The volumes of respondents in other department groups are too small to comment on.

Figure 12: Proportion of respondents in each collaboration group – by QLD Government department



Furthermore, a greater proportion of respondents from all departments reported that collaboration with the QMHC will be essential to achieving their organisation's future strategic goals (73%) than reported that the current level of collaboration is sufficient to meet their current strategic goals (42%) (Figure 12).

Taken together, this suggests that there is scope for the QMHC to increase its understanding of how it may work better with other government departments and facilitate achievement of their strategic goals.

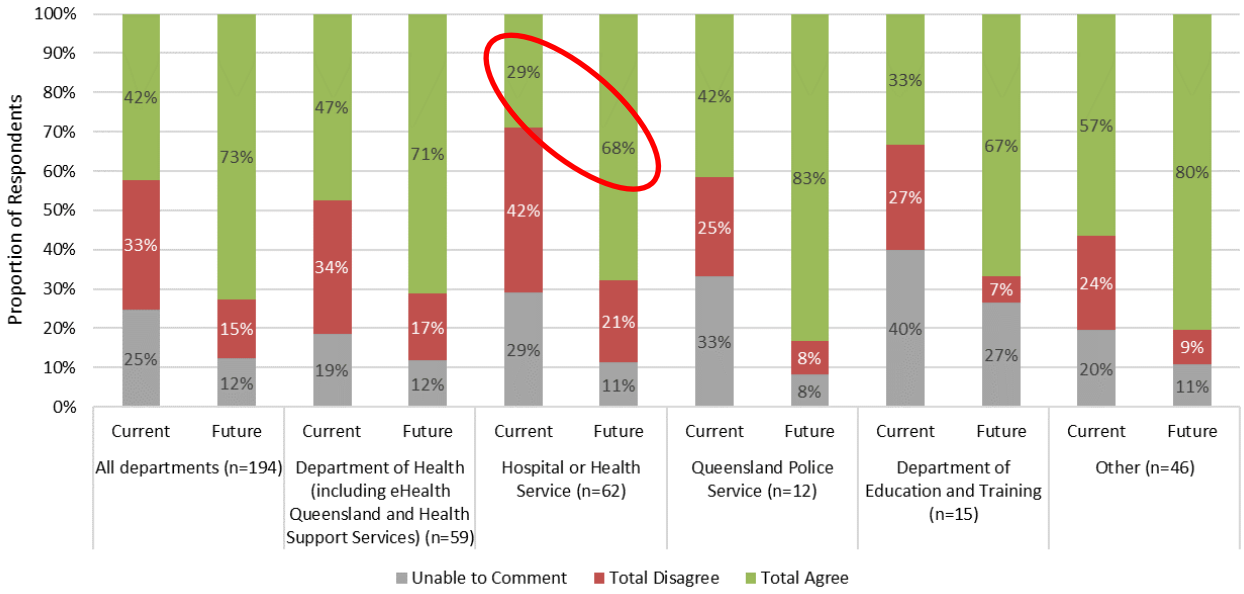
Areas QMHC not doing well:

"Lack of direct engagement with Mental Health Services in the HHS in meaningful ways"

- *2016 Survey respondent*

Consistent with other results, one of the key stakeholder groups the QMHC must form stronger collaborative relationships with are the HHSs. Almost 70% of HHS respondents saw collaboration with the QMHC as being essential to meeting future strategic goals, whereas only 29% of this group saw that the current level of collaboration was sufficient to meet their current strategic goals.

Figure 13: Perceived sufficiency of current collaboration versus perceived future need for collaboration with QMHC



A key function of the QMHC is to develop, monitor and review implementation of a whole of government strategic plan (the Strategic Plan). As part of this function it must foster the development and strengthening of partnerships and the integration of services across relevant agencies. The evaluation sought to assess and monitor stakeholder perceptions with respect to the QMHC's effectiveness in facilitating cross- and whole-of-government collaborations in support of mental health, drug and alcohol issues.

Areas QMHC doing well:

"Profile and understanding across government around mental health improved substantially."

- *2016 Survey respondent*

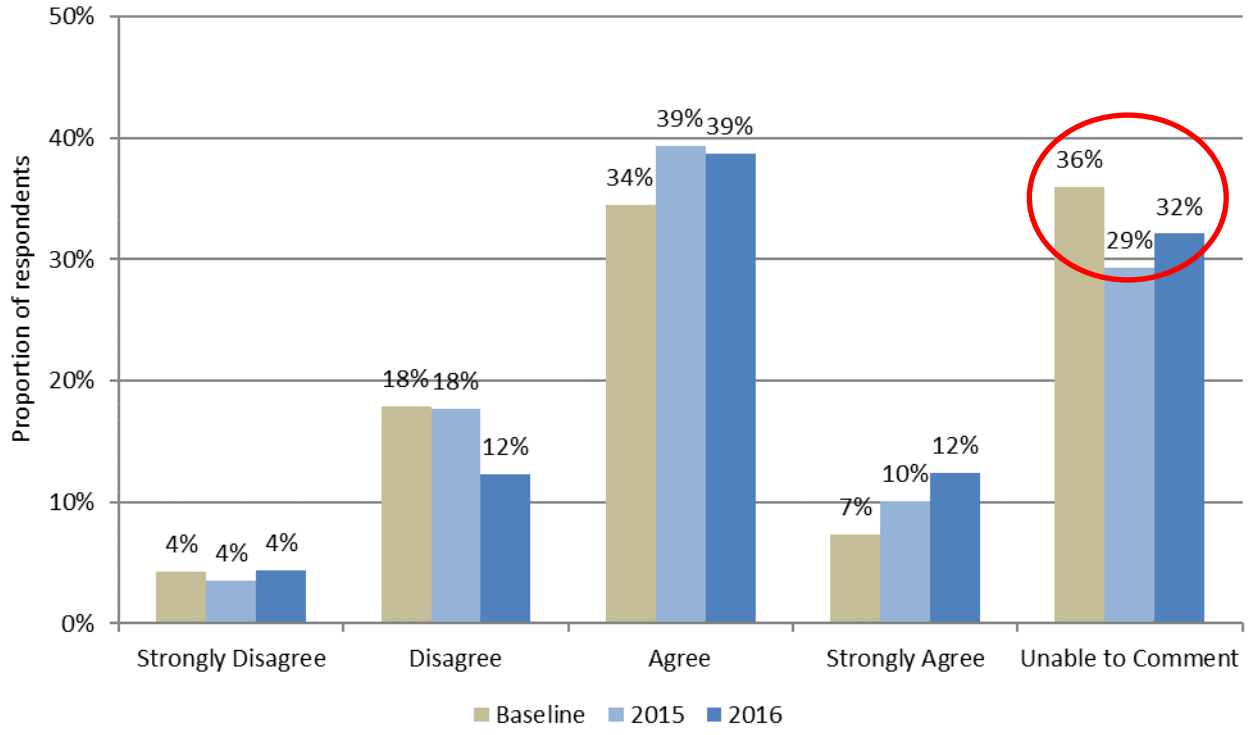
Areas QMHC not doing well:

"I have not heard much about what changes have been implemented and how successful they are."

- *2016 Survey respondent*

The majority of respondents across all years agreed that the QMHC is helping to improve collaboration across sectors (increasing from 41% in 2014 to 51% in 2016). However, almost a third of respondents reported being unable to comment (Figure 14), suggesting that more promotion of the QMHC's cross-sectoral activities may be beneficial.

Figure 14: *"The QMHC is helping to improve collaboration across sectors (e.g. between health and justice, education, community etc.)"*



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

This evaluation question was designed to assess how well the QMHC has facilitated effective collaborations between stakeholders within specific departments and organisations. As a 'backbone' organisation, the QMHC must build strong connections with cross-sectoral players to broker and mediate relationships between groups. Part of the planned approach to Stage 3 of the evaluation included targeted workshops with key stakeholders to assess the QMHC's role in improving collaboration between key parties. However, due to the amount of other activity in the mental health space and within the QMHC, these workshops were rescheduled to the first quarter of 2017.

Nonetheless, the survey results suggest that, at least within the Mental Health, Health and Drug and Alcohol sectors, an increasing proportion of respondents over the last three years agree that the QMHC is helping to improve collaboration within the mental health, drug and alcohol sectors (Figure 15). Notably, there were substantial gains in this sentiment amongst respondents from the Drug and Alcohol sector (2016: 69% vs 2015: 46%). This may be reflective of the QMHC's work with Queensland Network of Alcohol and other Drug Agencies (QNADA) on the development and launch of the Queensland Alcohol and Drug Action Plan in 2016.

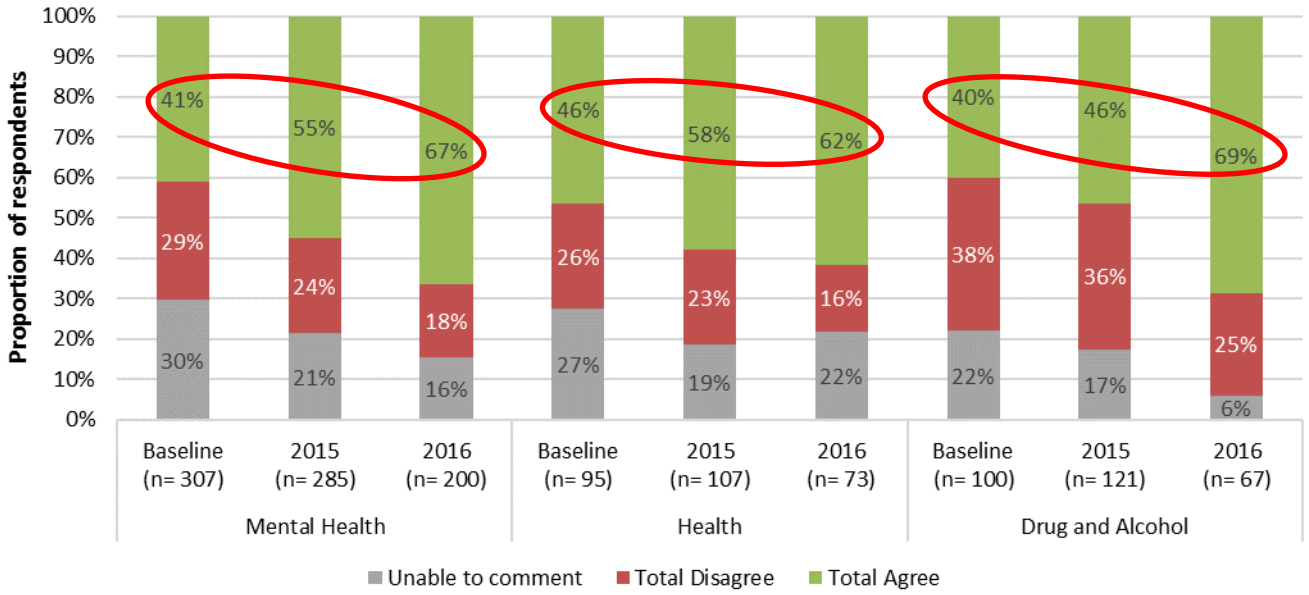
> *"Collaboration between the DoH MHAODB and the QMHC does not seem to be effective"*
>
> - *2016 Survey respondent*

While there has been gains in the number of survey respondents reporting effective collaboration between health and mental health, survey respondent feedback also suggested that this collaboration could still be strengthened.

Management Comment

As the system matures, the extent to which Queensland Health has a role in fostering this collaboration needs to be considered. The recommendations of the Barrett Inquiry have pointed to the importance of getting a better understanding of the role of Queensland Health as the system manager.

Figure 15: "*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?

In the 2015/16 period, the Commission worked in collaboration with government and other bodies to:

- Develop and release three Action Plans to support implementation of the Strategic Plan
  - *Early Action: Queensland Mental Health Promotion, Prevention and Early Intervention Action Plan 2015–17*
  - *Queensland Suicide Prevention Action Plan 2015–17*
  - *Queensland Alcohol and other Drugs Action Plan 2015–17*.
- Further develop (both expected to be released before the end of 2016):
  - *Queensland Rural and Remote Mental Health and Wellbeing Action Plan 2016-18*
  - *Queensland Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Action Plan*
- Provide grants to 14 organisations to support local action
- Developed a joint submission with the Antidiscrimination Commission Queensland to a national inquiry into employment
- Responded to numerous invitations to join interagency projects eg including youth, social housing.
- Commence projects and initiatives to promote wellbeing, such as developing options to expand Ed-LinQ and regional wellbeing hubs
- Develop and release the first annual *Performance Indicators Report* (discussed further in Section 4.5).

It is too early to comment on the impact of these new arrangements. However, the QMHC's focus on developing robust Action Plans to support implementation of the Strategic Plan, and supporting practical initiatives for change, shows an appropriate shift towards putting systems in place for a sustainable whole of government effort. This should begin to address the stakeholder feedback reported in prior years that the QMHC, while helping to drive the strategic directions for the mental health, alcohol and drug sectors, must also support translation of the strategy into action.

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

Given that the QMHC does not directly deliver services, in order to achieve impacts for the mental health, drug and alcohol sectors, it is critical that it works with and builds effective and sustainable collaborations with partners. In addition, as a 'backbone' organisation it must facilitate the same *between* partners.

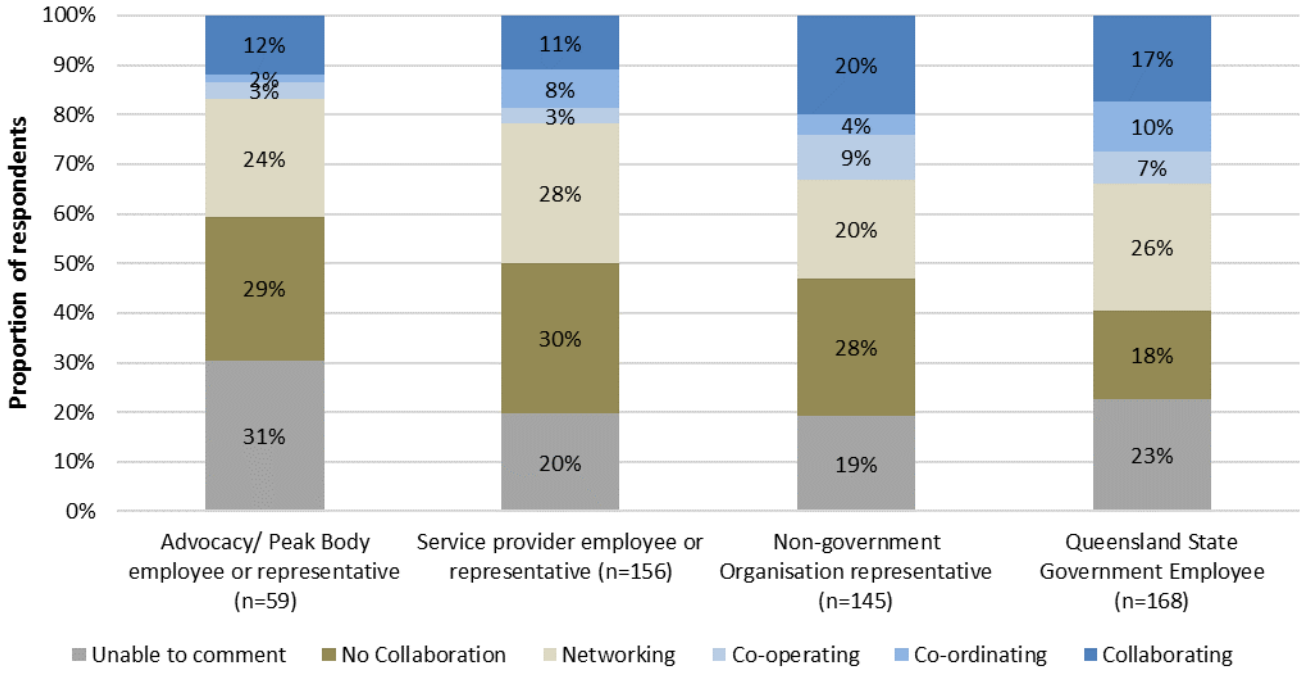
As described in Section 4.2.1.2, the effectiveness of the QMHC in facilitating collaboration between third-party groups was intended to be assessed via targeted workshops that have now been re-scheduled. However, the survey investigated only the level of collaboration between respondent's organisations and the QMHC (Figure 16).

Around half of respondents reported being unable to comment or that there was no collaboration between their organisation and the QMHC. However, it is encouraging that between 14% and 27% or respondents indicated that their organisation was at a relatively high level of collaboration maturity (either co-ordinating or collaborating), especially given the relative young age of the Commission overall.

> *Areas QMHC doing well:*
>
> *"Forming and maintaining contacts with key agencies, particularly the non-government and carer sector agencies."*
>
> - *2016 Survey respondent*

The group with the largest proportion of respondents reporting some level of collaboration with the QMHC were Queensland State Government Employees (59% in total at least Networking), followed by Non Government Organisations (53%), Service provider employee or representatives (50%) and Advocacy/Peak Body employee or representatives (40%).

Figure 16: *"Please select the statement that best describes the level of collaboration between your organisation and the QMHC"*- by role



4.2.2 Summary

The largest proportion of respondents (41%) reported that their organisation had no/low level of current collaboration with the QMHC and that this was not sufficient to achieve their current strategic goals. However, a third reported mid-high level of collaboration with the QMHC and that this was sufficient to achieve their current strategic goals.

An increasing proportion of respondents in each survey year reported that the QMHC is helping to improve collaboration within the mental health, drug and alcohol sectors, with the largest improvement seen for AOD stakeholders in the 2016 year.

Encouragingly, respondents from all sectors reported that collaboration between their organisation and the QMHC will be essential to achieving their future strategic goals, irrespective of the current levels of perceived collaboration.

It is not necessary for the QMHC to be at a high level of collaboration with every stakeholder group (e.g. co-operating/co-ordinating may be sufficient in many cases). However, over the coming years, the QMHC must work to reduce the proportion of its stakeholders that are unable to comment on the level of collaboration between their organisation and the QMHC and build on current relationships to move them towards an appropriate level of collaboration for their joint objectives.

4.3 QMHC Profile

Evaluation of QMHC Profile

To what extent is the Commission seen as being credible to influence QLD MH policy?	How well is the work of QMHC known by its stakeholders?	How effective have the Commission's engagement activities been?	To what extent is the Commission seen as taking an effective leadership role?	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?

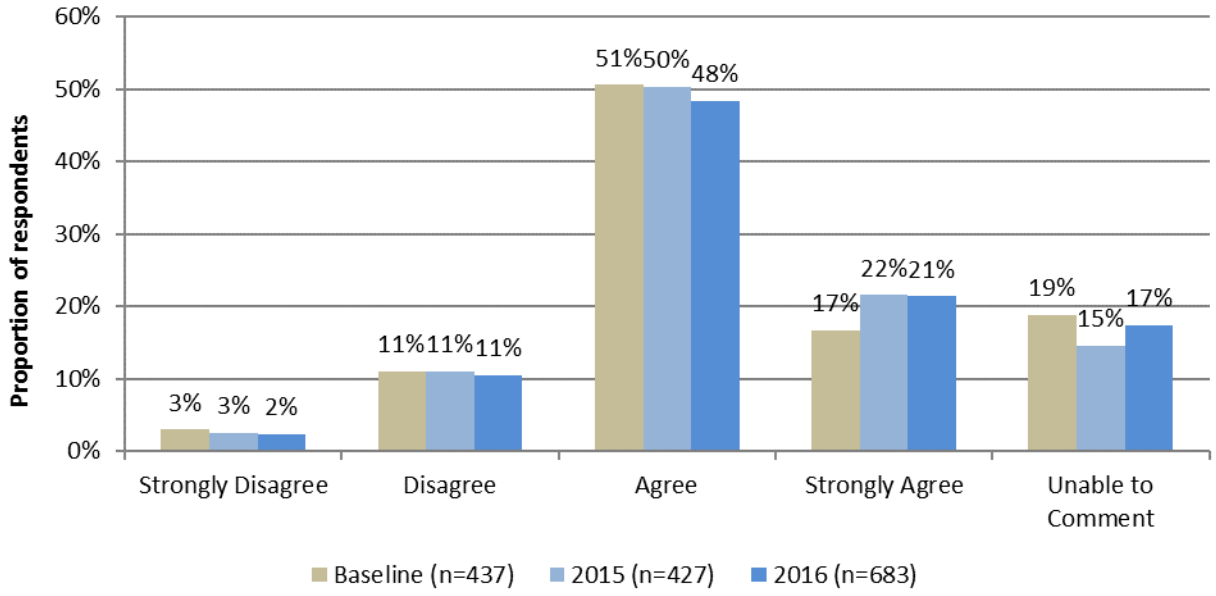
4.3.1 Key Findings

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

About half of respondents across all three surveys agreed that the QMHC is seen as a credible organisation (Figure 17). Encouragingly, an additional ~20% of respondents strongly agreed that the QMHC is seen as a credible organisation. In 2016, there was a slight decline in the proportion agreeing with this question and an approximately commensurate increase in the proportion of respondents that indicated being unable to comment.

While not considered to be significant, it is likely that this slight shift may be due to the slightly lower general knowledge of the mental health, drug and alcohol sectors amongst the 2016 survey respondents (see Figure 10).

Figure 17: ***"I believe the QMHC is seen as a credible organisation"***



Over the last three years, the proportion of survey respondents agreeing that the QMHC is operating independently of Government has increased by almost 10% (from 45% in 2014 to 54% in 2016) (Figure 18).

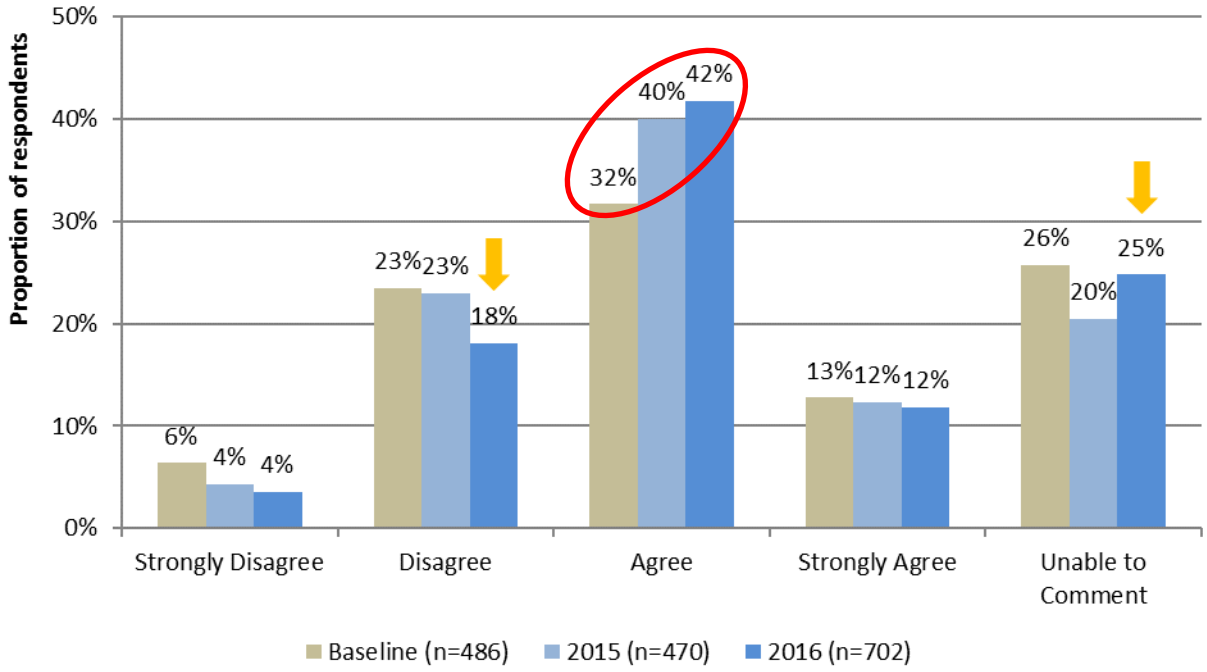
In 2016, there was also a 5% decrease in the proportion disagreeing with the statement, and a commensurate increase in the proportion reporting being 'unable to comment'.

Areas QMHC doing well:

"QMHC makes strong efforts to be independent of government and government services, focussing strongly on community-based services and consumers of services."

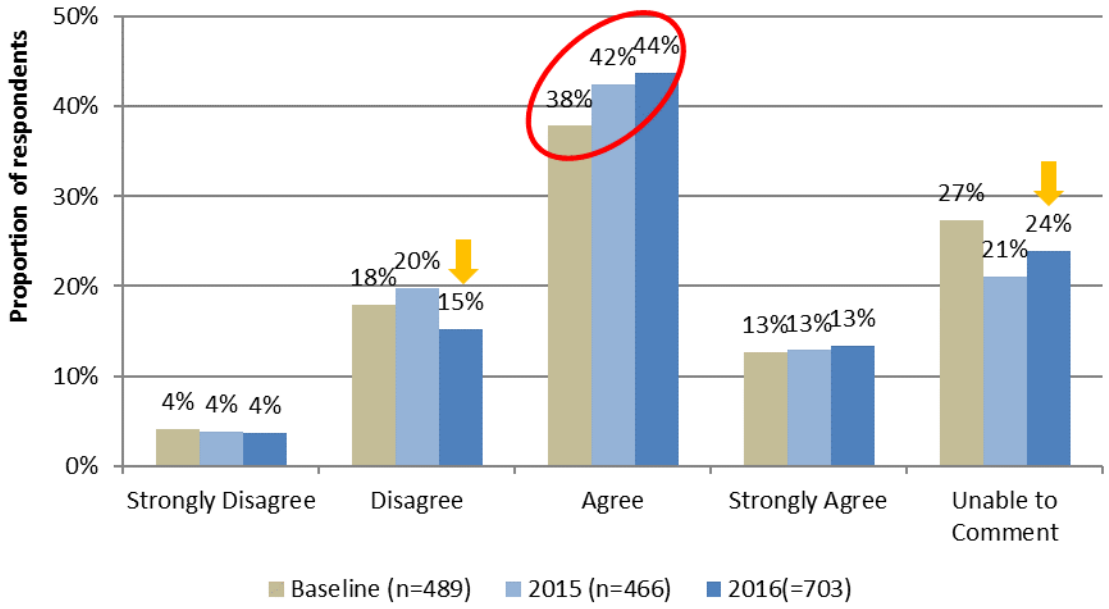
- *2016 Survey respondent*

Figure 18: ***"The QMHC is operating independently of Government"***



Similar trends, albeit slightly less-pronounced, were observed amongst respondents when asked if the QMHC is operating independently of Queensland Health and other government agencies (51% agreeing in 2014 increasing to 57% in 2016) (Figure 19).

Figure 19: *"The QMHC is operating independently of Queensland Health and other government agencies"*



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

Consistent with previous years, the majority of 2016 survey respondents (63%) did not believe that there is a high level of awareness of the QMHC (Figure 20). Again, consistent with previous years, over 90% of respondents felt able to provide a response to the question (i.e. did not select "Unable to Comment"), the greatest proportion of all survey questions.

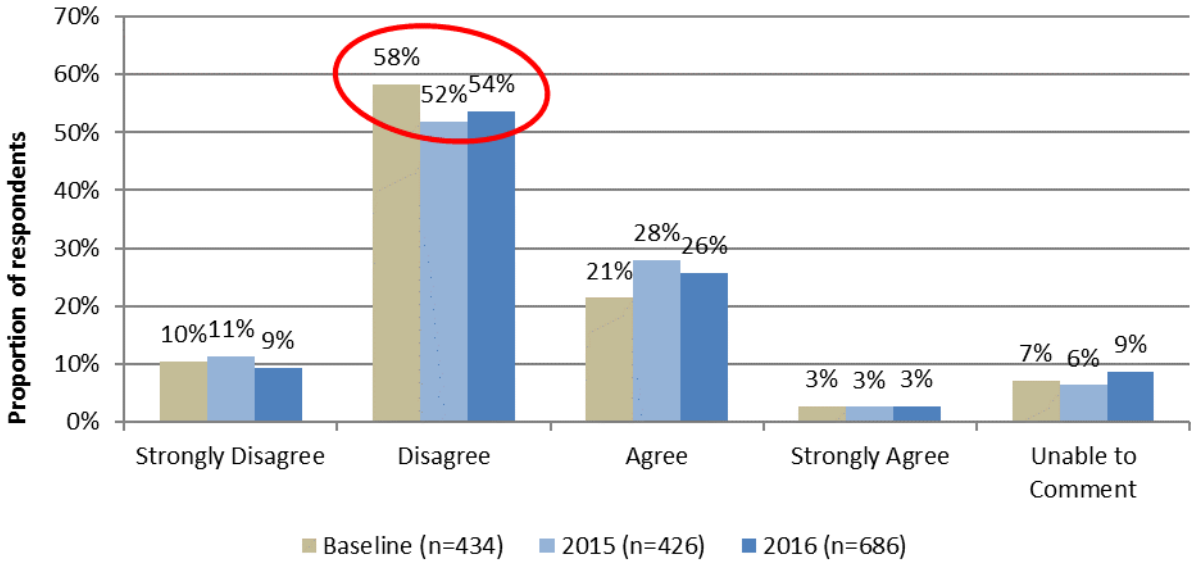
This significance of this continued trend is compounded by the fact that the sample for this question was over ~60% larger than for the previous years. This suggests that the result holds across a broader base of respondents.

> *"Most people have never heard of the QMHC and even people like myself within the sector are not aware of their activities"*
>
> - *2016 Survey respondent*

Management Comment

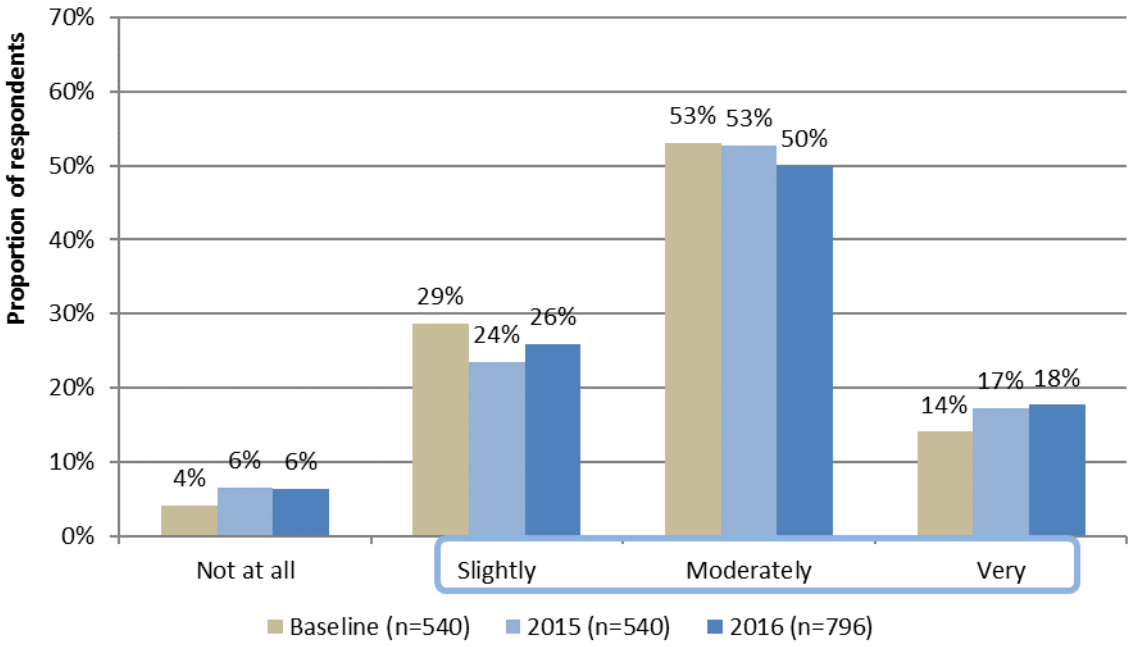
This observation raises a major issue for the Commission in striking the appropriate balance between raising awareness but not setting expectations that the Commission is unable to meet, either because it lies outside our mandate or because there are insufficient resources to address those expectations

Figure 20: ***"I believe there is a high level of awareness of the QMHC"***



Somewhat contradicting the result above, almost all survey respondents (94%) reported themselves as being at least slightly familiar with the QMHC and the work that it does, with almost 20% reporting being 'very' familiar (Figure 21).

Figure 21: ***"To what degree are you familiar with the QMHC and the work that it does?"***



Taken together, these results suggest that while respondents report being familiar with the QMHC and the work it does, they did not feel that the wider community has a high level of awareness of the QMHC. This suggests a need for the QMHC to continue its focus on promotion and awareness and engaging more with stakeholders who are not currently captured as survey respondents.

> *"as time passes more people are getting to know what the QMHC is doing"*
>
> - *2016 Survey respondent*

Respondents who reported being at least 'slightly' familiar with the QMHC and the work that it does (blue box above) answered a series of additional questions regarding their understanding of the QMHC. Consistent across all three survey years, the majority of these respondents reported being interested to know more about the work

of the QMHC, while slightly lower proportions reported understanding the relationship between the work of the QMHC and their work or life, or understanding the role of the QMHC (data not shown).

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

The Commission engages stakeholders through a variety of modes, both in person and via electronic and paper-based means.

In 2015, the Commission launched a dedicated Facebook page to promote its activities and engage a new audience. In 2015, the QMHC Facebook page received close to 500 'likes', and this almost doubled (to 950) in 2016. Similarly, in 2015 the QMHC Facebook page achieved 5,875 organic post reach and this increased by over 700% in 2016 (to 47,752 organic post reach). Further testament to the effectiveness of this medium is the fact that almost 10% of respondents reported engaging with the QMHC via this medium.

Similarly, over twice the proportion of respondents in 2016 compared to 2015 (7% in 2016 compared to 3% in 2015) reported engaging with the QMHC via Twitter.

The proportion of respondents reporting interacting with the QMHC via almost all other engagement mediums declined in 2016. This may be reflective of the fact that the proportion of survey respondents reporting "No Contact" with the QMHC almost doubled between 2015 and 2016 (from 7% in 2015 to 13% in 2016). This may suggest a higher proportion of 2016 respondents that are potentially 'new' to the Commission.

Figure 22: Modes of interaction with the QMHC

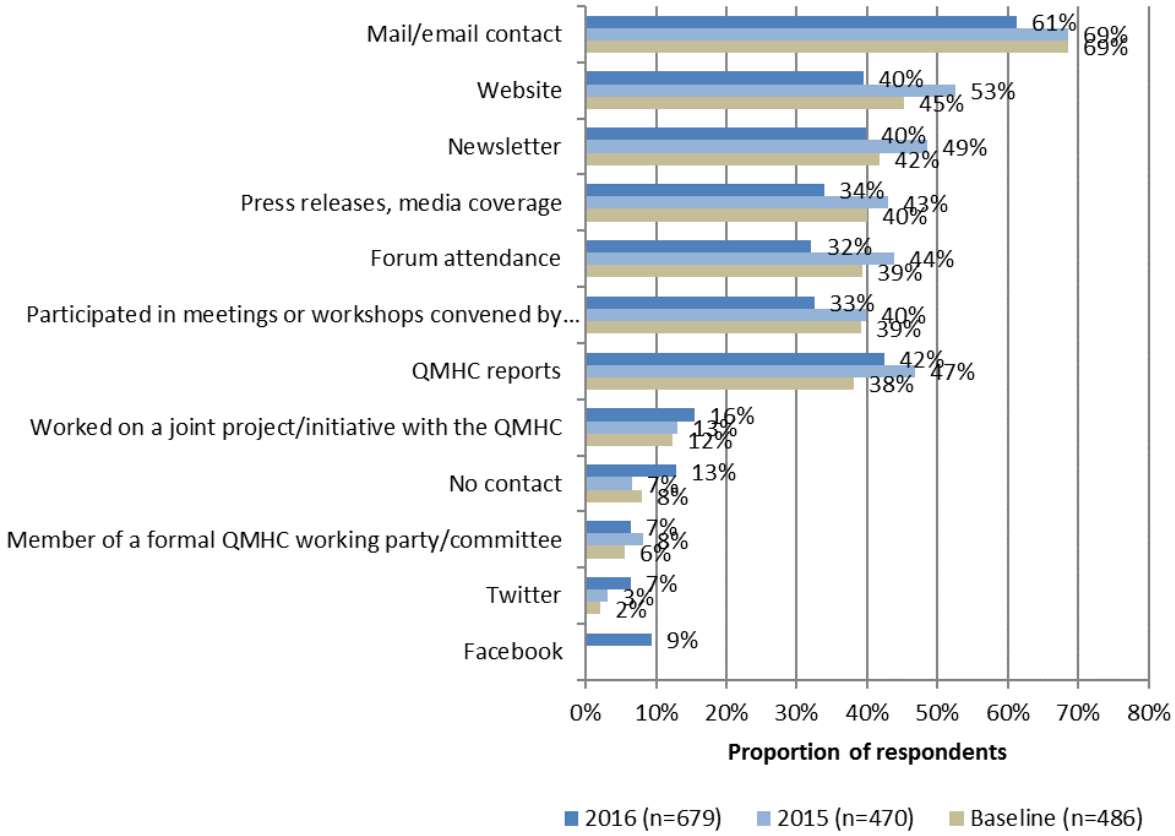


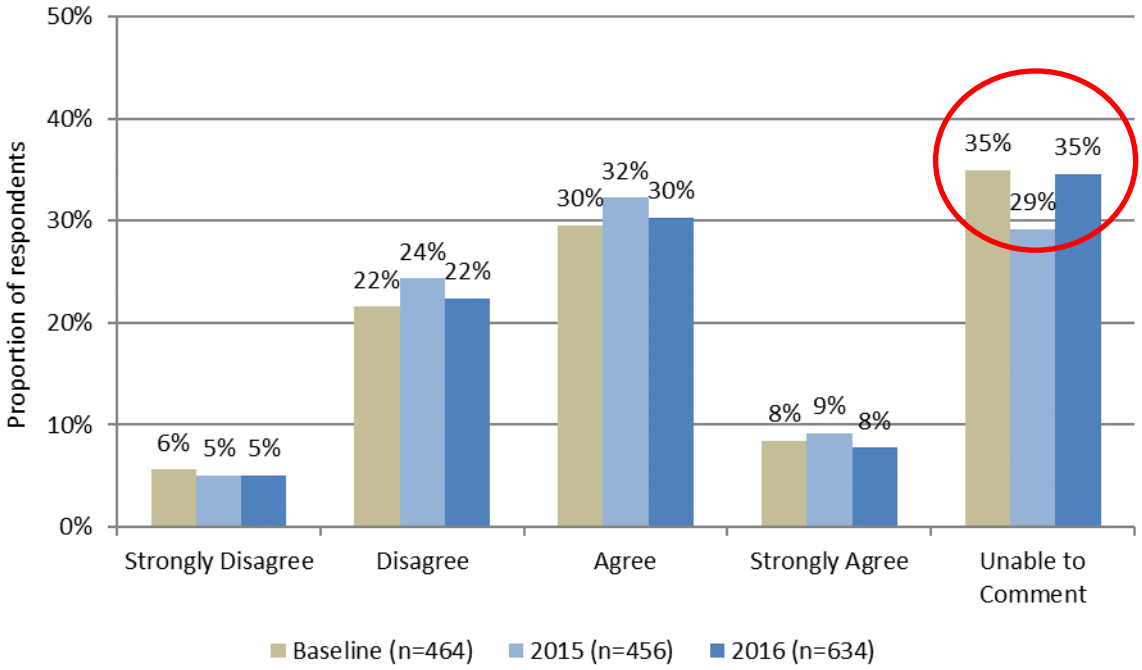
Figure 23 shows that across all years, a slight majority (38% to 41% in total) agreed that the QMHC is engaging the full range of relevant stakeholders. However, another 27% to 29% reported disagreeing with the statement.

After a decrease in 2015 in the proportion of respondents reporting being "Unable to comment" on the question, the proportions returned to 2014 levels in the most recent survey (35%). These results suggest that the QMHC still has some

> *"Need to engage the whole range of parctioners (sic) in the field not just organisational leaders and those in policy making. People who are DELIVERING services in education and other areas need to not just health focused services. "*
>
> *- 2016 Survey respondent*

progress to make with respect to both broadening its engagement with relevant stakeholders and increasing the awareness of its engagement activities amongst its broader stakeholder base.

Figure 23: "*The QMHC is engaging the full range of relevant stakeholders.*"



Over the last three years, the proportion of respondents reporting that they had had sufficient opportunities to provide input into QMHC work has increased (Figure 24). In 2016, although the proportion that 'agree' declined by approximately 6%, the proportion that 'strongly agree' increased by 4%.

Areas QMHC doing well:

"Seeking broad input"

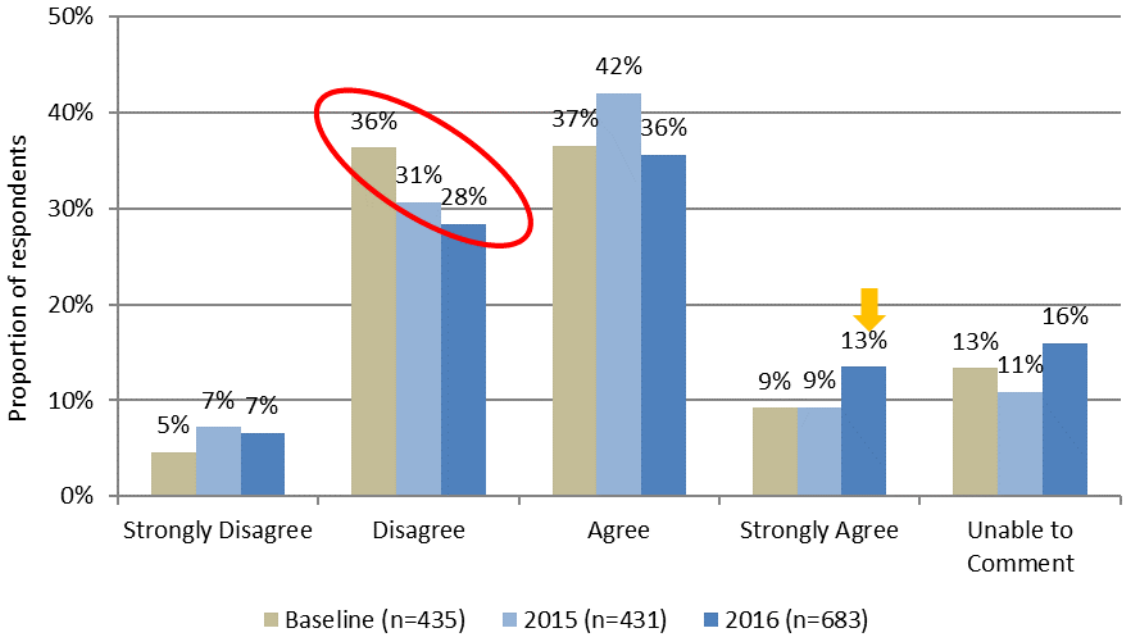
- *2016 Survey respondent*

While the cumulative proportion of respondents who 'disagree' or 'strongly disagree' that they have had sufficient opportunity to provide input into QMHC work has declined year on year since 2014, this group still represented almost 40% in 2016. This suggests that further opportunities, or an improvement in the quality of opportunities (e.g. deeper engagement), for stakeholder input may be required.

"[Need] More visibility of QMHC to the general public and within the sector and more opportunities for input (formal and informal) from the sector"

- *2016 Survey respondent*

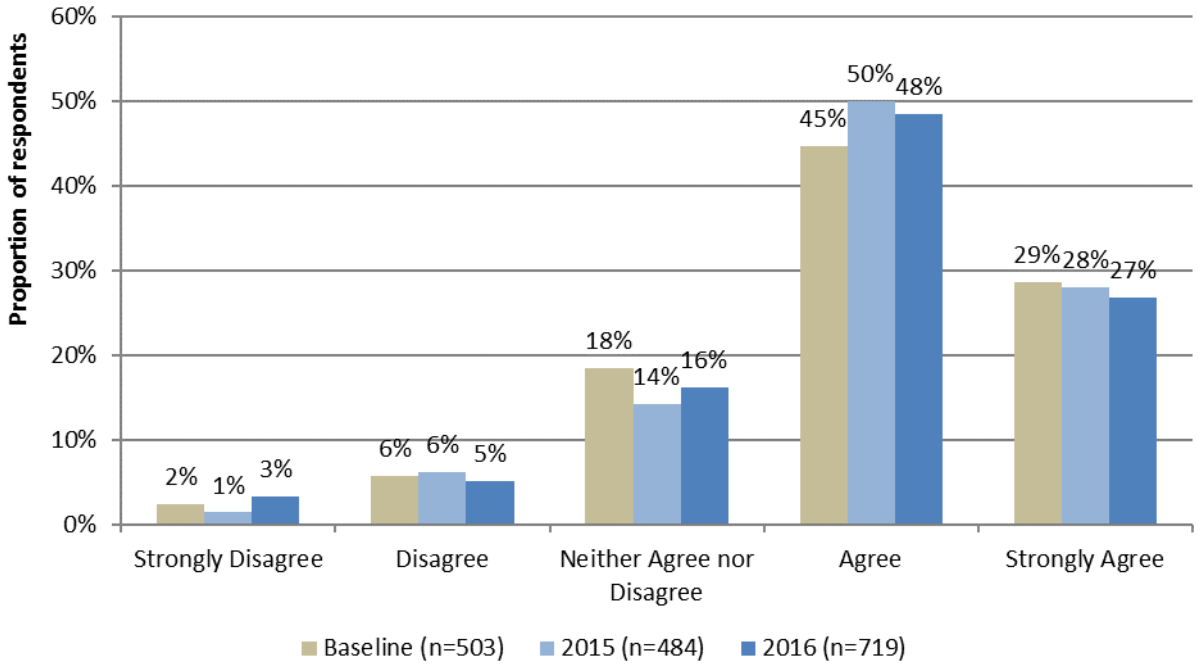
Figure 24: *"I have had sufficient opportunities to provide input into QMHC work."*



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

As a backbone organisation[9], the Commission is expected to take a leadership role in addressing key mental health, alcohol and other drugs issues and progressing whole-of-government reform. Approximately three-quarters of all question respondents viewed the QMHC as an important driver of reform of the mental health, drug and alcohol system in Queensland (Figure 25).

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



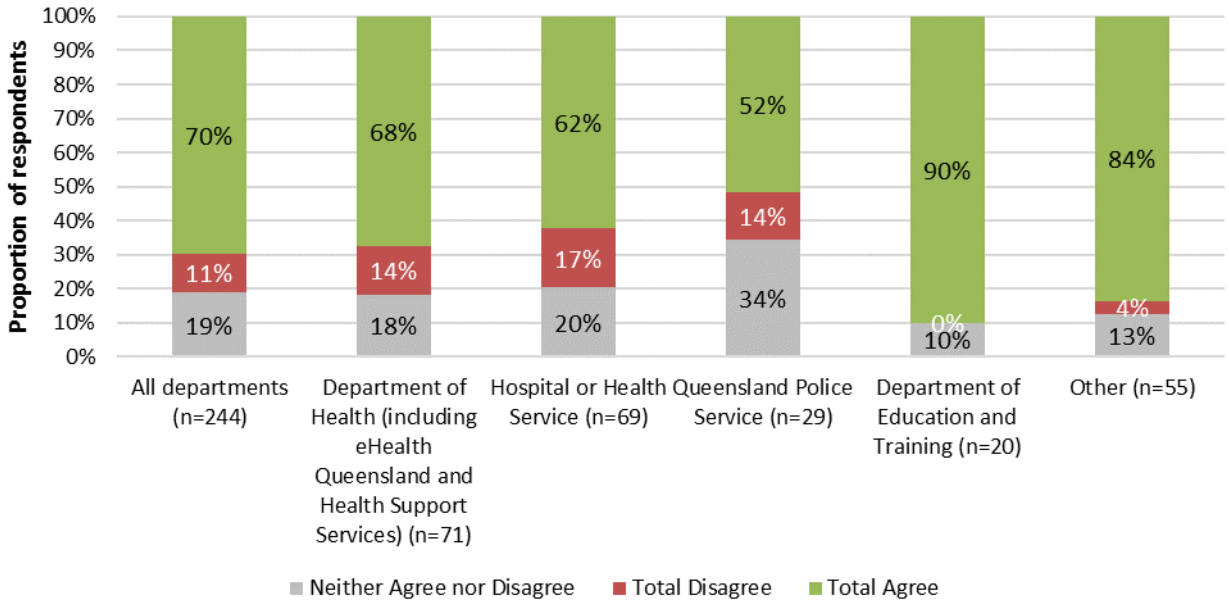
While still the majority in all cases, lower proportions of respondents from Queensland Police (52%), hospital or health services (62%) viewed the QMHC as an important driver of reform (Figure 26). However, within these groups, larger proportions were non-committal (i.e. selected "Neither Agree nor Disagree") – 34% for Queensland

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

Police and 20% for hospital or health services. This suggests that the Commission may need to employ specific activities to shift the perceptions of these groups.

Contrastingly, 90% of respondents from the Department of Education and Training viewed the QMHC as an important driver of reform of the mental health, drug and alcohol sectors in Queensland, albeit from a small sample volume.

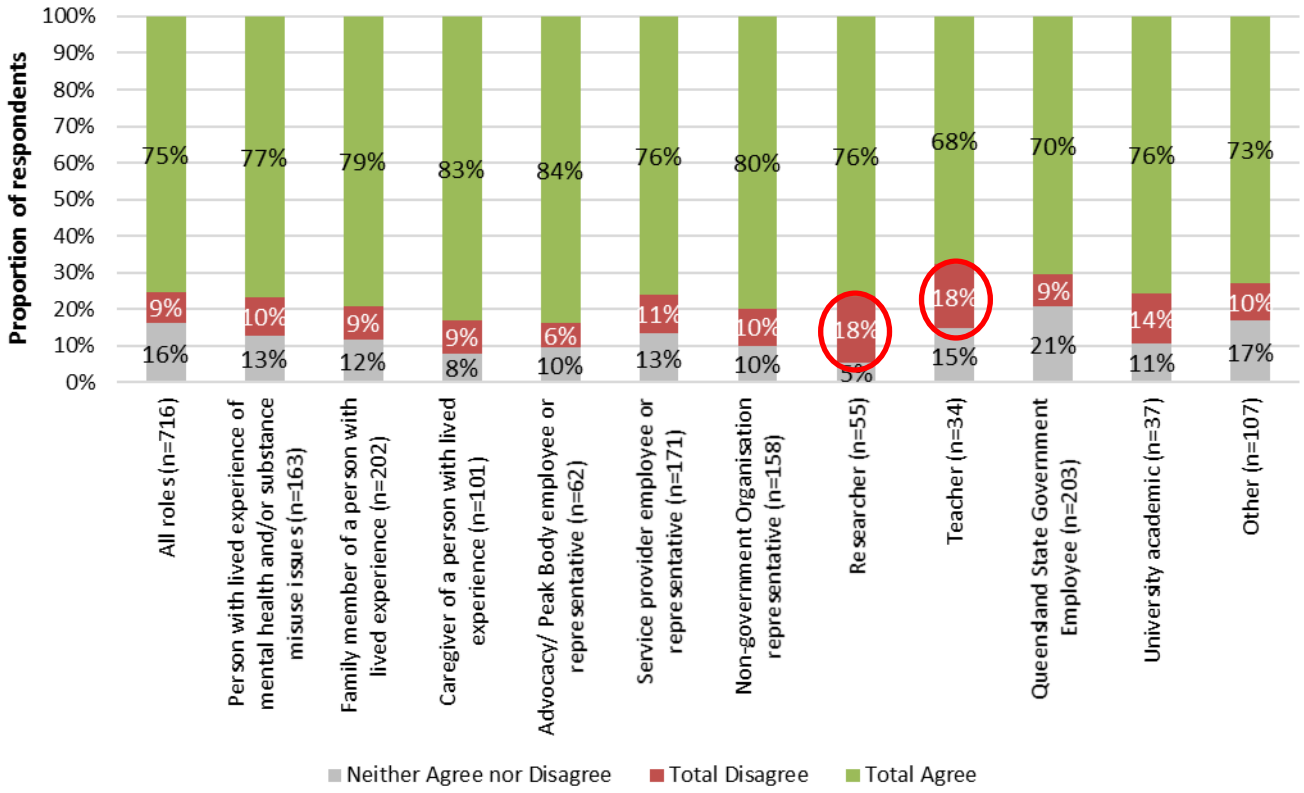
Figure 26: *"I view the QMHC as an important driver of reform of the mental health, drug and alcohol system in QLD"* – by QLD government department



When breaking down the question by personal role, the results largely mirrored the aggregate results, with a few exceptions. Greater proportions of respondents than average identifying as people with lived experience (77%), or family members (79%) or caregivers (83%) of people with lived experience viewed the QMHC as an important driver of reform.

While the majority of Researchers and Teachers reported agreeing (76% and 68%, respectively), the proportion who reported disagreeing that the QMHC is an important driver of reform (18% in both cases) were double the average of 9%.

Figure 27: "*I view the QMHC as an important driver of reform of the mental health, drug and alcohol system in QLD*" – by personal role



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?

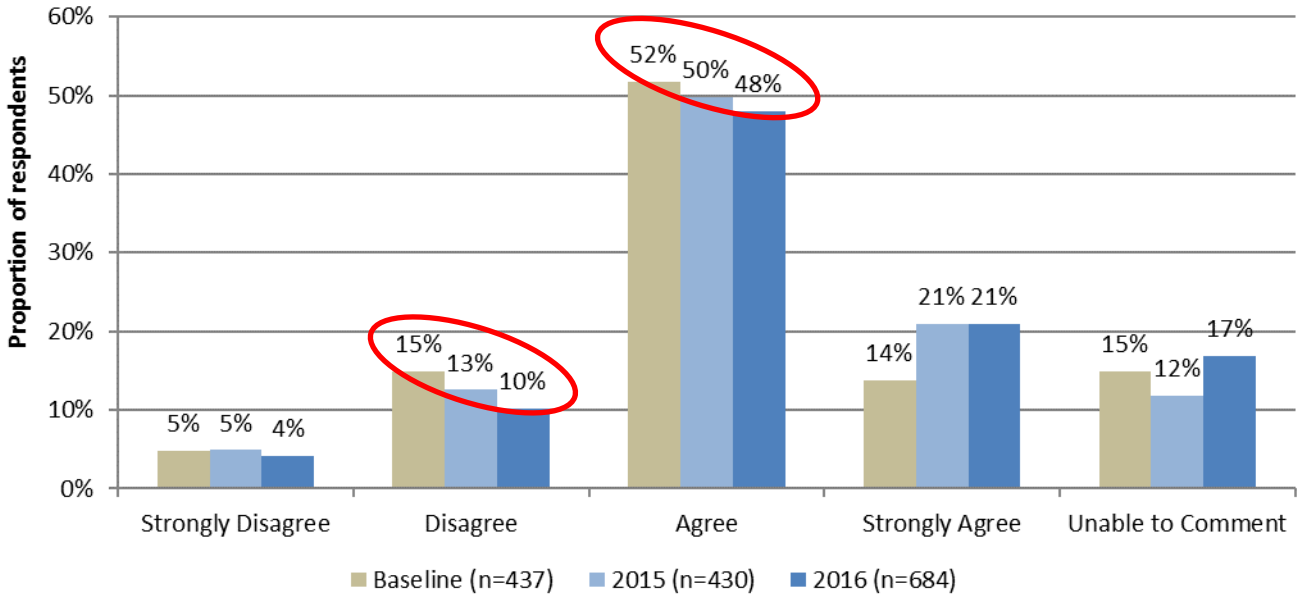
A key requirement of a 'Backbone organisation' is the ability to effectively identify and understand the key issues that need to be addressed to achieve Collective Impact. The Commission's capacity to be effective in this areas is fundamental to its performance overall.

Approximately 70% of survey respondents across all years believed that the QMHC has demonstrated a sound understanding of the mental health, drug and alcohol issues in QLD (Figure 28). While there was a slight downward trend in this proportion across the three surveys, there was an increase in the proportion of respondents that 'Strongly Agree' in 2015 and remained static in 2016. In addition, a similar downward trend was observed in the proportion disagreeing across years, suggesting that there has been an overall improvement in stakeholder perceptions that the QMHC has demonstrated sound understanding of mental health, drug and alcohol issues.

> *"The QMHC is doing some great work in identifying the issues and bringing together key players to address them."*
>
> - *2016 Survey respondent*

Furthermore, 62% of survey respondents in both 2015 and 2016 believed the Strategic Plan identifies priorities that are important to them (see Figure 32 in Section 0).

Figure 28: *"I believe the QMHC has demonstrated a sound understanding of the mental health, drug and alcohol issues in QLD"*



4.3.2 Summary

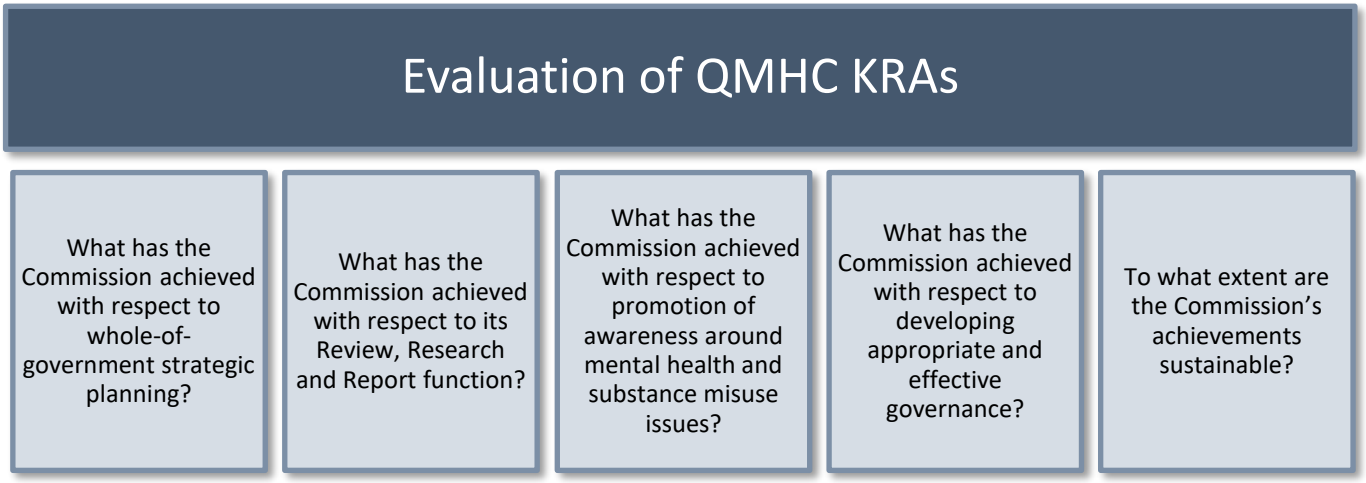
Key to its role as a collaborative capacity builder, the majority of respondents across all survey years saw the QMHC as a credible organisation. In addition, an increasing proportion of respondents across the three years saw the QMHC as operating independently from Government and Queensland Health and other departments.

A significant area for improvement is the awareness of the QMHC, given that a consistently high majority across each survey year disagreed that there is a high level of awareness of the QMHC. Similarly, there is still work to be done in engaging the full range of relevant stakeholders and providing more (and potentially greater quality) opportunities to input into QMHC work.

Despite these shortfalls, a consistently high majority (75%) across the three years saw the QMHC as a key driver of reform.

Respondents reported engaging with the QMHC through various means, and the QMHC's social media strategies in particular appear to be successful with high (and increasing) levels of engagement reported through these channels year on year.

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

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

4.4.1 Strategic Planning

The Honourable Lawrence Springborg MP launched The Strategic Plan[10] on 9 October 2014 following extensive consultation with stakeholders across Queensland. In the initial consultations undertaken between June-July 2014 for Stage 1 of the evaluation, 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.

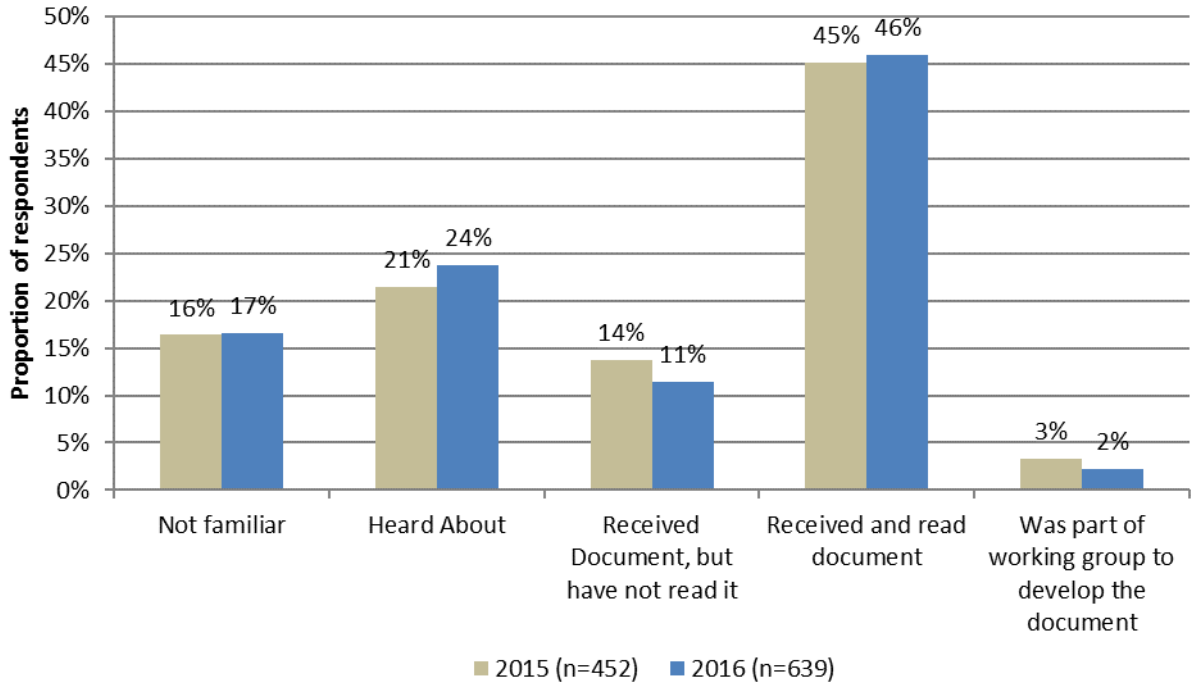
As such, the 2015 Survey introduced a series of questions focused specifically on understanding stakeholder perceptions of the Strategic Plan in terms of its content and the potential for it influence change and benefits across the mental health, alcohol and other drugs system in QLD.

The majority (~83%) of question respondents in both 2015 and 2016 were familiar with the Strategic Plan to at least some degree. Almost half of the question respondents in both 2015 and 2016 reported having received and read the document (Figure 29), while a slightly higher proportion of 2016 respondents (24%) than 2015 respondents (21%) reported having just heard about the Strategic Plan, with a commensurate decrease in the proportion that had received the document, but had not read it.

In terms of dissemination of the Strategic Plan document, survey results suggest that the QMHC should focus on improving awareness amongst the approximately 40% of respondents that had only heard about, but not received the document, or were not familiar with it at all.

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

Figure 29: Familiarity with the Strategic Plan – overall



When looking at familiarity with the Strategic Plan by organisational role, there was substantial improvement in the proportion of Board/Executive respondents reporting having received the Strategic Plan (2016: 80% vs 2015: 67%), with most of the observed improvement being in those overall having read it (2016: 69% vs 2015: 50%) (Figure 30).

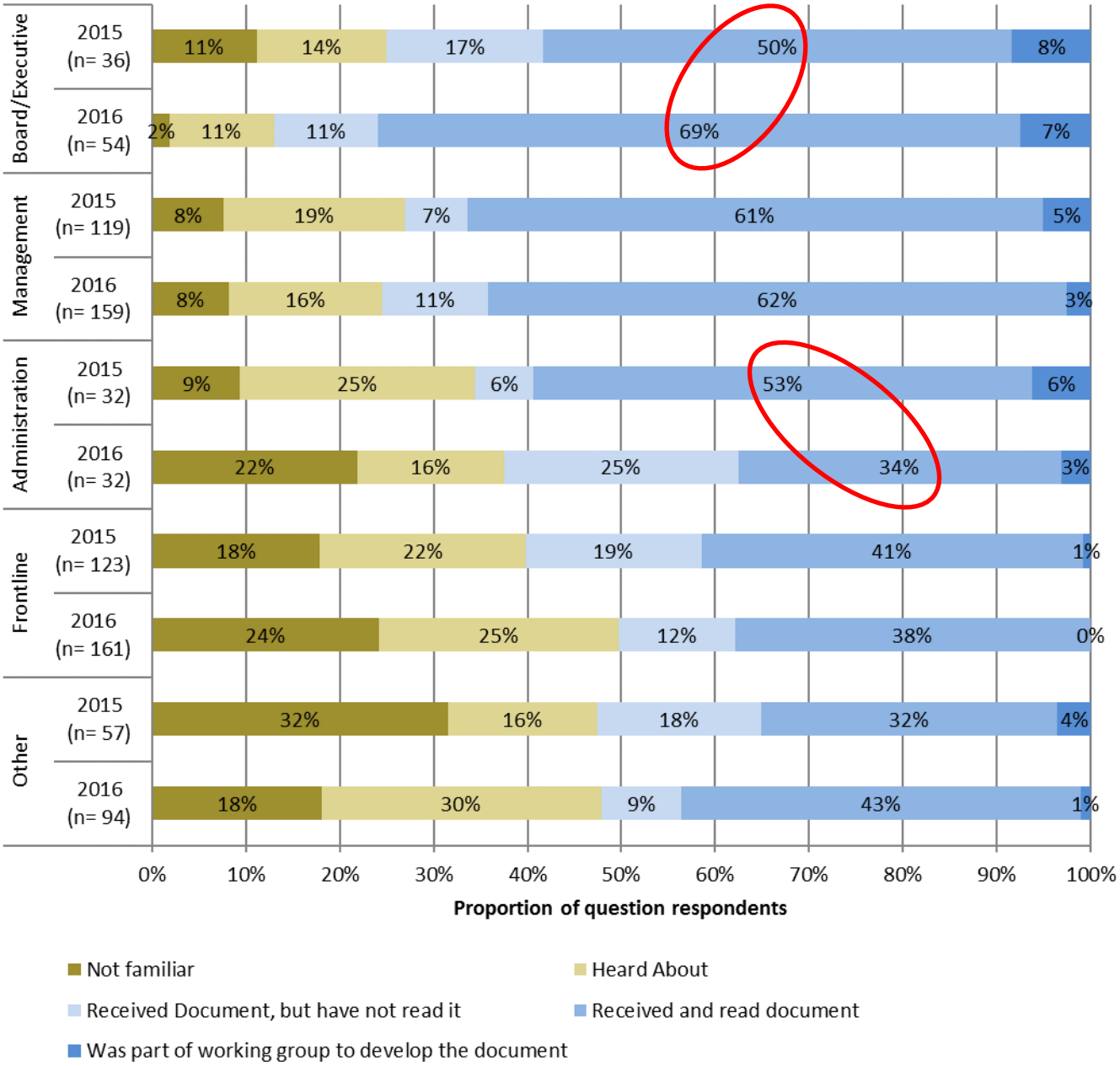
An approximately equivalent proportion (~61%) of respondents identifying as Management across 2015 and 2016 had received and read the document, but a slightly higher proportion of 2016 respondents (11%) reported having received the document but not read it, compared to 2015 (7%).

While equivalent proportions (59%) of respondents indicating their role as Administration reported having received the document in both 2015 and 2016, there was a substantial decline in the proportion that had read the document in 2016 (34%) compared to 2015 (53%). Caution should be applied in interpreting this result however, due to the low overall number of respondents (n=32).

Approximately 10% fewer 2016 respondents identifying their role as Frontline reported receiving the Strategic Plan (50%) compared to 2015 respondents (60%).

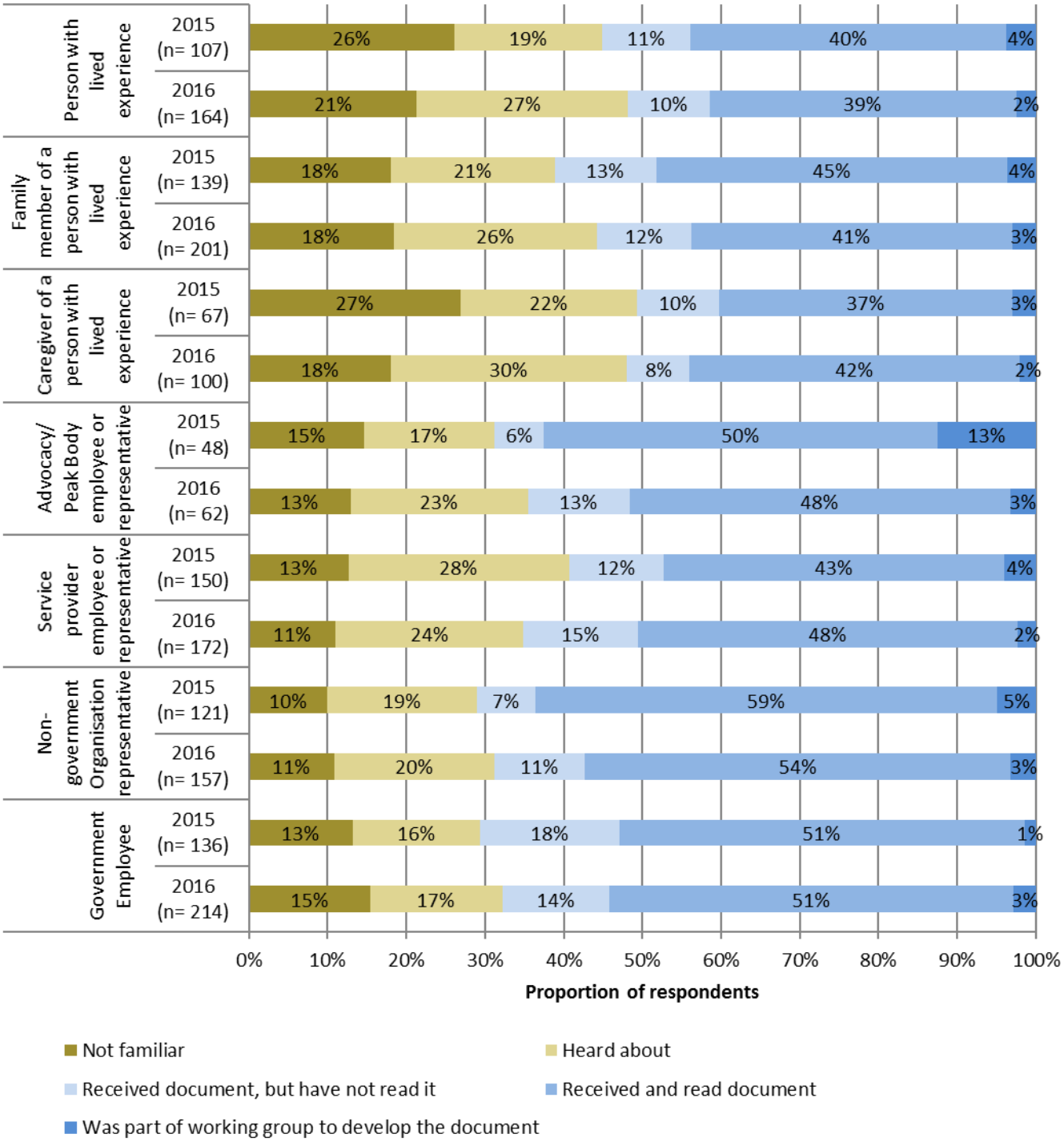
Frontline staff were the least likely respondents, by organisational role, to have received and read the Strategic Plan in both 2015 (41%) and 2016 (38%). This suggests that there is still opportunity to improve dissemination of the Strategic Plan to Frontline service providers through targeted promotion and distribution. However, given their role, it is also likely that Frontline staff will relate more closely to the Action Plans developed to operationalise the Strategic Plan.

Figure 30: Familiarity with Strategic Plan - by respondent organisational role



Across all personal role groups, either an approximately equivalent or greater proportion of respondents in 2016 had at least heard about the Strategic Plan. Encouragingly, about 50%-60% of respondents in both 2015 and 2016 that identified as either people with lived experience, family members or caregivers, reported having received the document.

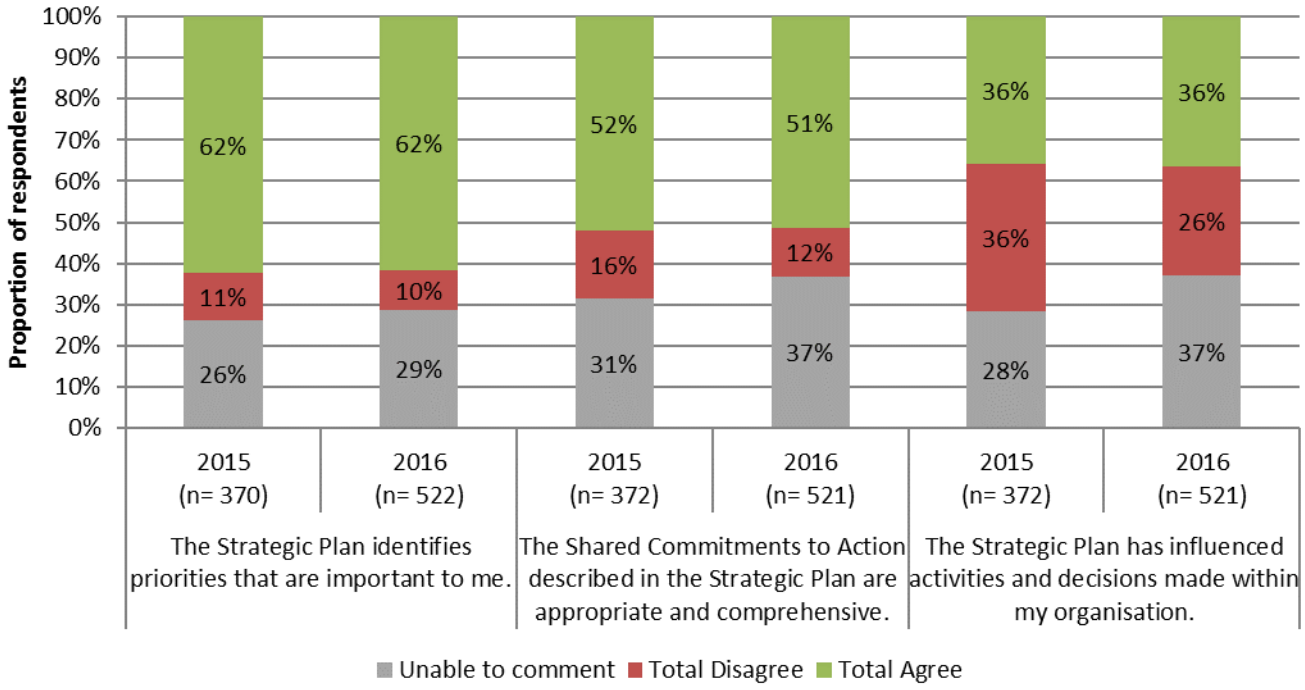
Figure 31: Familiarity with Strategic Plan - by respondent personal role



The majority of question respondents in both 2015 and 2016 (62%) indicated that they felt the Strategic Plan identified priorities important to them (Figure 32). About half of respondents in each year each indicated that the Shared Commitments to Action are appropriate and comprehensive, and 36% in both years indicated that the Strategic Plan had influenced activities and decisions in their organisation. A slightly higher proportion of respondents to each question in 2016 reported being unable to comment. However, this may be expected due to the broader dissemination of the survey in 2016 compared to prior years.

> *"Strategic Plan provides an enabling framework"*
>
> - *2016 Survey respondent*

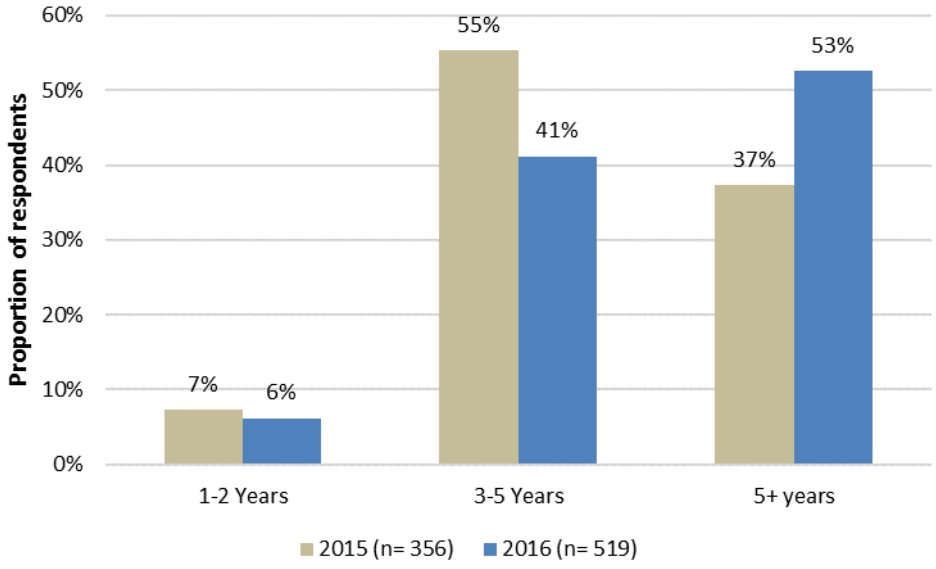
Figure 32: Relevance of Strategic Plan



The majority of survey respondents in both 2015 and 2016 (~93%) indicated that they expected it to be three years or more before the wider impacts of the Strategic Plan on the mental health, alcohol and other drugs sectors were observed (Figure 33). In fact, a year on from the release of the Strategic Plan, survey respondents appear to have substantially shifted towards a perception that more than five years will be required to observe wider impacts (2016: 53% vs 2015: 37%).

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[11]. This may also suggest that as stakeholders understand more about what is required for reform, and the timescales for certain initiatives, they may be more inclined to adjust their expectations toward a longer term outlook.

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



[11] 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.

4.4.1.1 Summary

The majority of respondents had at least heard about the Strategic Plan. The largest proportions that had received and read the document identified as Management, Board/Executive, suggesting an opportunity to increase dissemination and awareness of the plan amongst frontline staff.

Most respondents also agreed that the Strategic Plan identifies priorities important to them. However, few reported that the Strategic Plan had influenced activities and decisions within their organisation.

Between 2015 and 2016, there was a shift in the timeframe that respondents perceived would be required to observe the wider impacts of the Strategic Plan, with the majority of 2016 respondents indicating that greater than five years is likely to be required. This may suggest that stakeholders are gaining a greater appreciation for the activities and initiatives required to effect reform at the system level.

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.

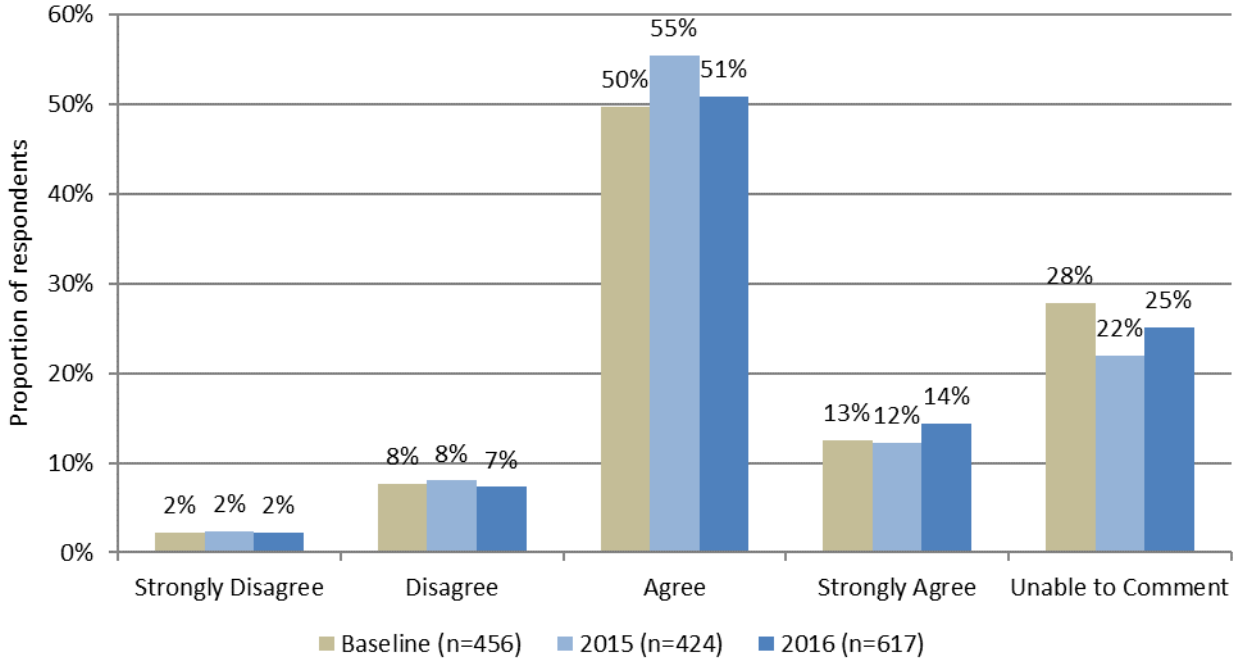
> *"I believe the QMHC undertakes valuable research and documents created are well distributed with the opportunity for comment."*
>
> - *2016 Survey respondent*

Key deliverables in 2015/16 included:

- Submissions to inform new mental health legislation for Queensland
- Submission to the Legal Affairs and Community Safety Committee of the Queensland Parliament which commenced an Inquiry into a Human Rights Act for Queensland
- Partnered with Enlightened Consultants to find out what makes for a positive experience of telepsychiatry and how the user experience might be enhanced in the future.
- Submission to the Australian Government on the Mental Health in Multicultural Australia (MHiMA) Project

Across all surveys (Baseline, 2015 and 2016), the majority (ranging from 63% to 67%) of respondents 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 around 10% of respondents in each survey disagreed with the statement (with the remainder 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."*



4.4.2.1 Summary

Following a substantial amount of activity in this KRA in the first two years of the QMHC's operation, activity in 2015/16 was largely reactive in response to government or legislative inquiries as the QMHC focused its efforts on developing a series of action plans to support implementation of the Strategic Plan.

Nonetheless, consistent with prior years, the majority of 2016 respondents agreed that the research, review and evaluation work that the QMHC is commissioning helps identify and respond to current and emerging issues and trends.

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.

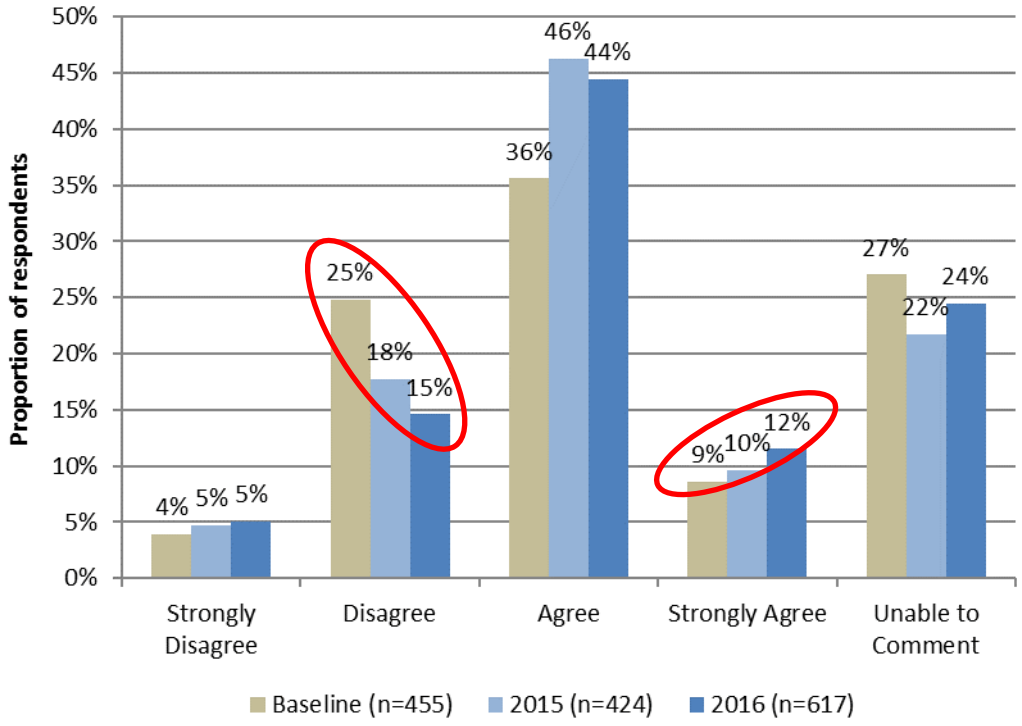
Across the three survey periods, there has been an increase in the proportion of respondents that agree the promotion and awareness work being undertaken by the QMHC is increasing community awareness and reducing stigma and discrimination (Figure 35). Notably in the 2016 survey, while an equivalent proportion (56%) of respondents reported agreeing overall, there was a slight shift from "Agree" to "Strongly Agree" compared to the 2015 survey. This suggests that further progress has been made in this KRA over the last year. Further supporting this finding is the fact that the proportion of respondents disagreeing with the statement reduced by a similar amount over the last year.

Areas QMHC doing well:

"Imprived (sic) promotion and awareness of mental health issues."

- *2016 Survey respondent*

Figure 35: *"The promotion and awareness work being undertaken by the QMHC is increasing community awareness and reducing stigma and discrimination".*



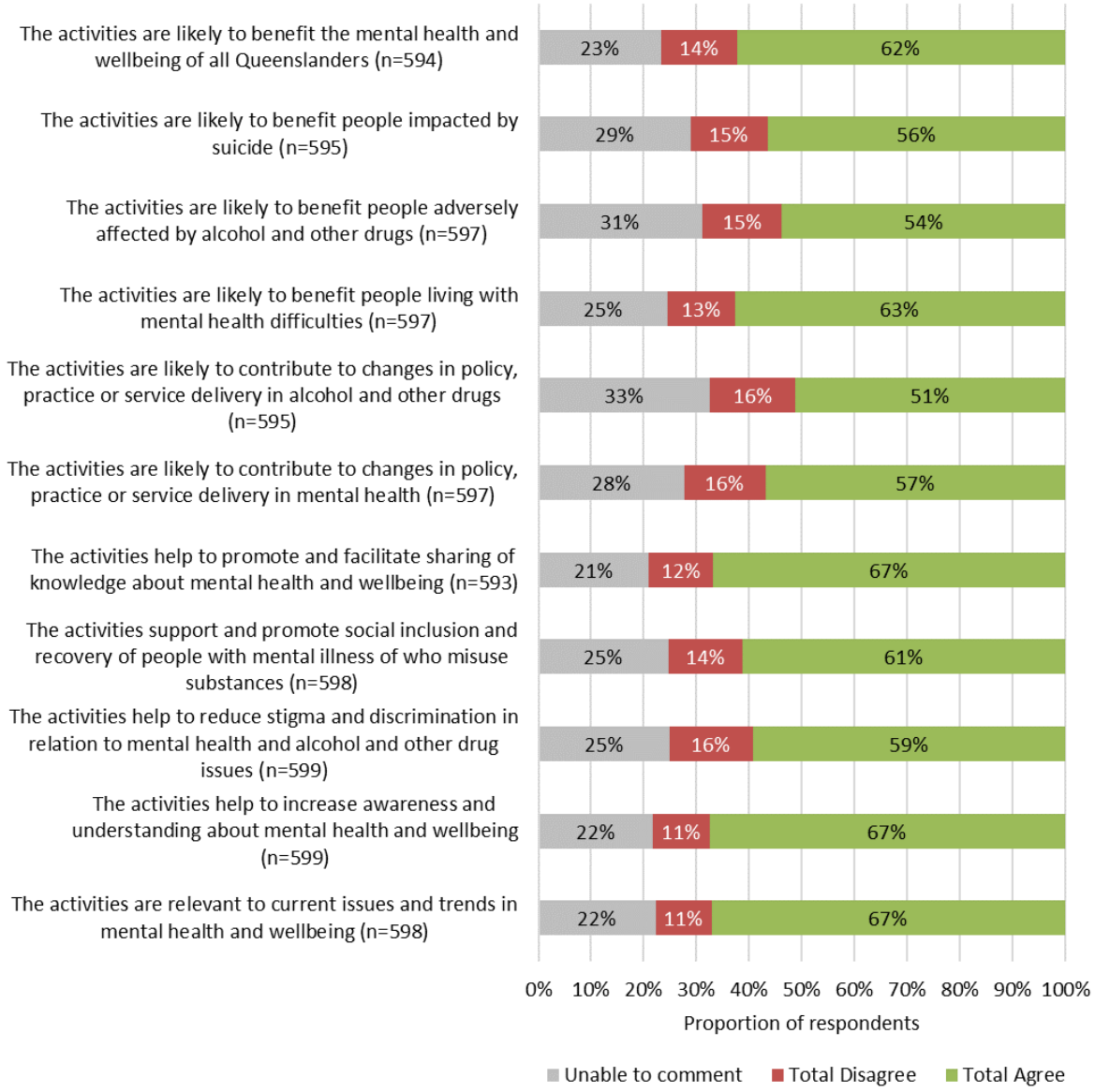
As described in the Stage 2 report, a targeted mini survey was planned for Stage 3 with a focus on the Promotion and Awareness KRA. However, due to competing activities, the stand-alone mini survey was instead incorporated into the annual survey. A series of additional questions regarding stakeholder perceptions of the benefits of the overall Promotion and Awareness activities were included along with questions specific to individual promotion and awareness initiatives.

Across all surveyed benefits, the majority of respondents were positive about the contribution of the promotion and awareness activities. The equal greatest proportion of respondents (67% in each case) agreed that the activities were relevant to current issues and trends in mental health and wellbeing and that the activities helped to increase awareness and understanding about mental health and wellbeing.

While still the majority, the lowest proportions of respondents agreed that the promotion and awareness activities were likely to contribute to changes in policy, practice or service delivery in alcohol and other drugs (51%) or to benefit people adversely affected by alcohol and other drugs (54%).

The Commission's focus on alcohol and other drugs has been an area identified for improvement in the previous two evaluation reports and in the 2015/16 year it continued work with QNADA to develop and release the Queensland Alcohol and Other Drugs Action Plan (AOD Action Plan). As such, it will be valuable to monitor stakeholder perceptions related to the Commission's work in AOD over the coming years as the AOD Action Plan is progressively implemented.

Figure 36: "Regarding the overall activities that the QMHC undertakes or commissions with respect to Promotion, Awareness and Early Intervention, please rate your agreement or disagreement with the following statements:"



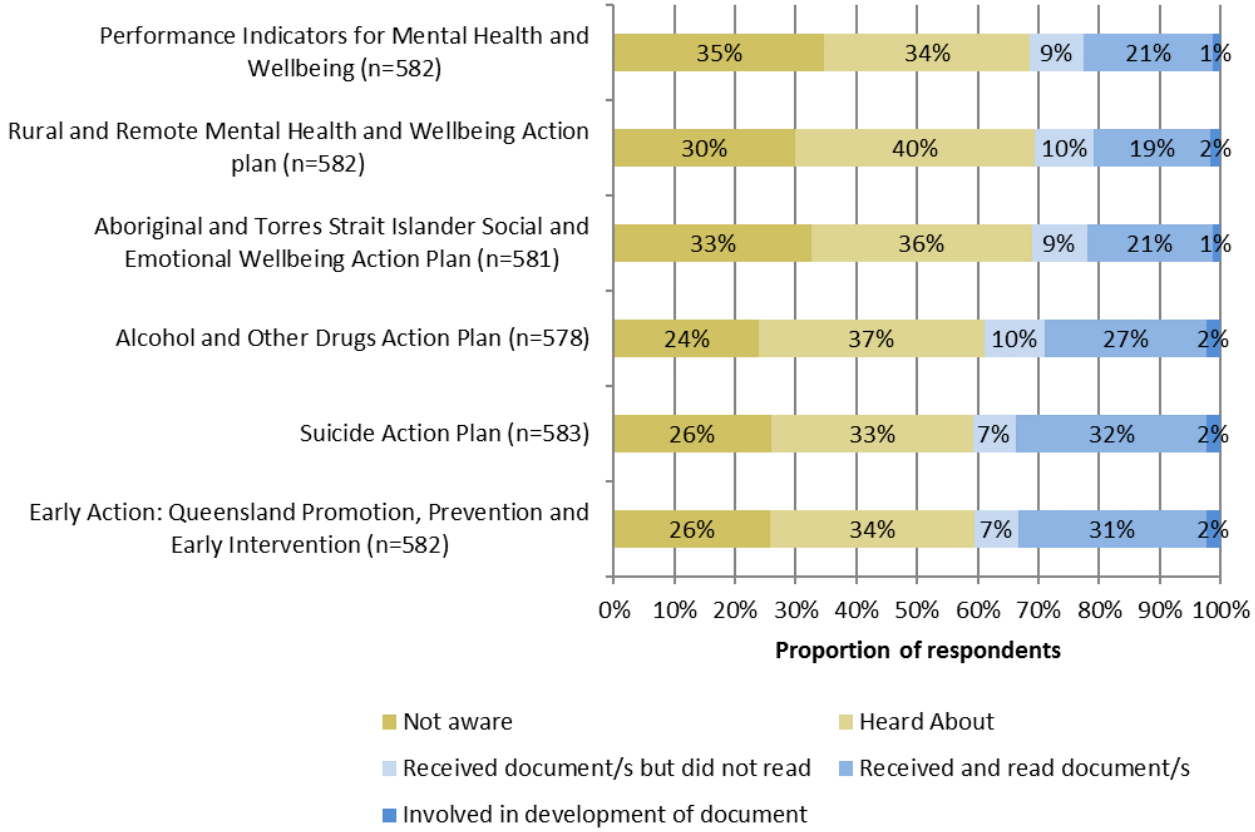
With respect to specific promotion and awareness initiatives, the majority of respondents (ranging from 65% to 74%) reported having at least heard about each initiative (Figure 37). However, a focus for the QMHC over the next year must be to undertake further targeted dissemination to increase the proportion of their stakeholders that have at least received, but ideally also read, the various Action Plans relevant to them.

Unsurprisingly, a greater proportion of respondents (~40%) reported having received the documents if the initiatives had culminated in a completed Action Plan in 2015/16 (e.g. Alcohol and Other Drugs Action Plan, Suicide Action Plan and Early Action: Queensland Promotion, prevention and Early Intervention). This was in contrast to the Rural and Remote Mental Health and Wellbeing Action Plan and the Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Action Plan where the documents are still under development and yet to be formally launched. In these cases, approximately 30% of respondents reported having received and read the documents, presumably referring to the progress updates and discussion papers that have been released in association with these initiatives.

"The development of action plans to drive change have been positive"

"I am involved with Suicide Prevention and I am pleased that QMHC has produced an action plan"

Figure 37: Please indicate your level of awareness of the QMHC's activities with respect to the following specific initiatives:



Feedback on the Action Plans was not all positive however:

> *"The subsidiary action plans (ie rural and remote, Aboriginal and Torres Strait Islander etc) creates too many layers of action plans with replicated or piecemeal actions that could have had a larger impact within one plan"*
>
> - *2016 Survey respondent*

> *"The drugs action plan lacked Visio (sic) and planning. It was basically a stock take. Very disappointing"*
>
> - *2016 Survey respondent*

The 2016 survey also asked respondents about their views on the Mental Health Week and World Suicide Prevention Day events in Queensland (Figure 38 and Figure 39, respectively). With respect to Mental Health Week, about half of all respondents agreed that the support from the QMHC was worthwhile, while the majority felt that more promotion is required (80% overall) and more support is required to host events (66% overall). A large proportion of respondents (35% overall) felt unable to comment on the value of the QMHC's support, suggesting that they may not have been aware of the QMHC's specific involvement in Mental Health Week.

Similarly, 27% of respondents felt unable to comment on whether more support is needed to host events. This may be due to the fact that a smaller proportion of respondents may be involved in hosting events.

The feedback was similar with respect to the World Suicide Prevention Day, where overall less than half (44%) agreed that the support from QMHC was worthwhile, the majority (75%) felt that more promotion was required and more support to host events was also required (62%). In the case of World Suicide Prevention Day, an even larger proportion of respondents (43% overall) felt unable to comment on the value of the QMHC's support and 34% felt unable to comment on whether more support is needed to host events. Taken together, these results suggest not only a desire for improved promotion of both events overall but also an increase in promotion of the QMHC's role in supporting these events.

Management Comment

The Commission is aware that many community groups would appreciate support to host Mental Health Week and World Suicide Prevention Day events in Queensland. However, this is not seen as a sustainable way of increasing state wide support and the current model for Mental Health Week of focusing on increasing access to generic information and merchandise was the preferred approach.

Figure 38: "Please rate your agreement or disagreement with the following statements regarding Mental Health Week" - by sector

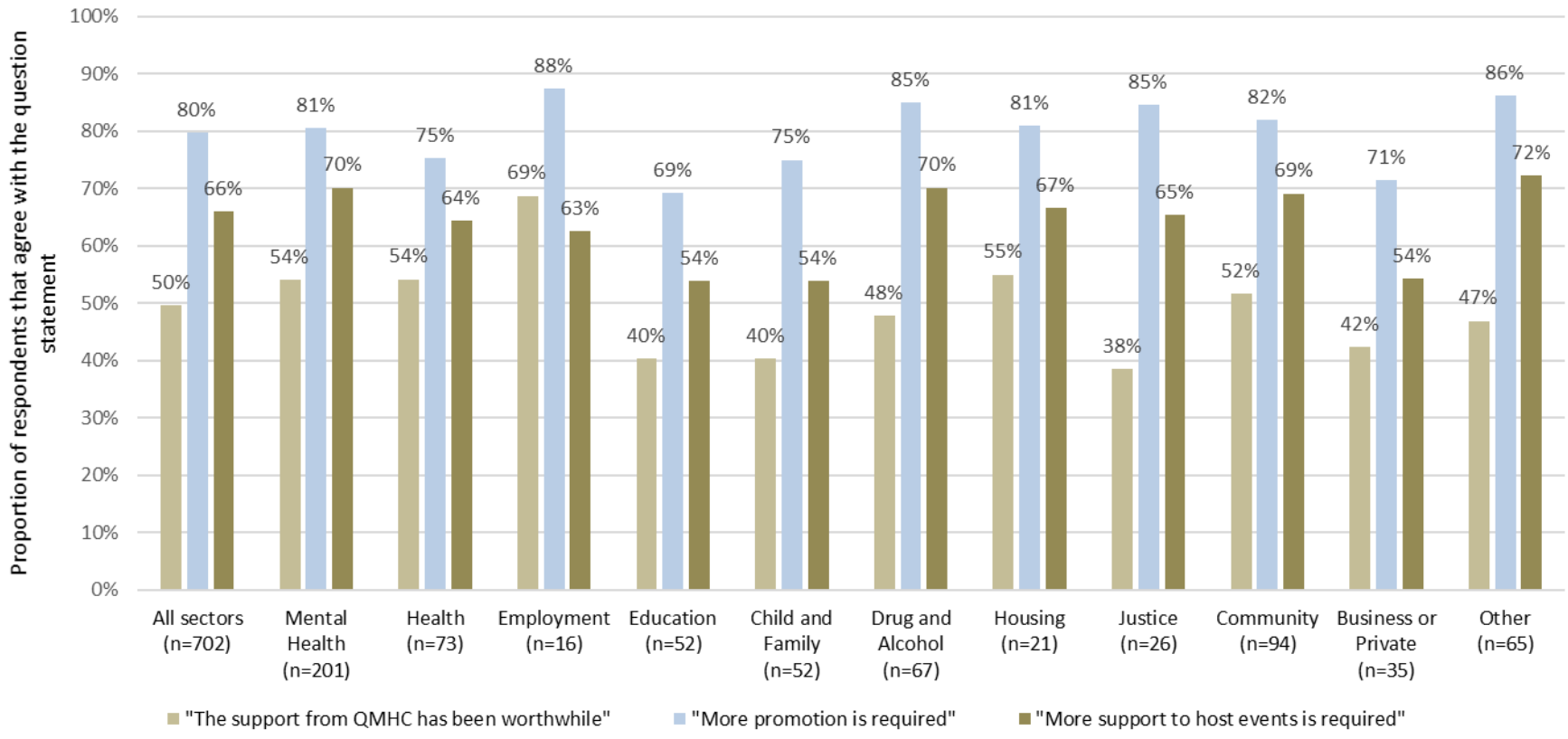
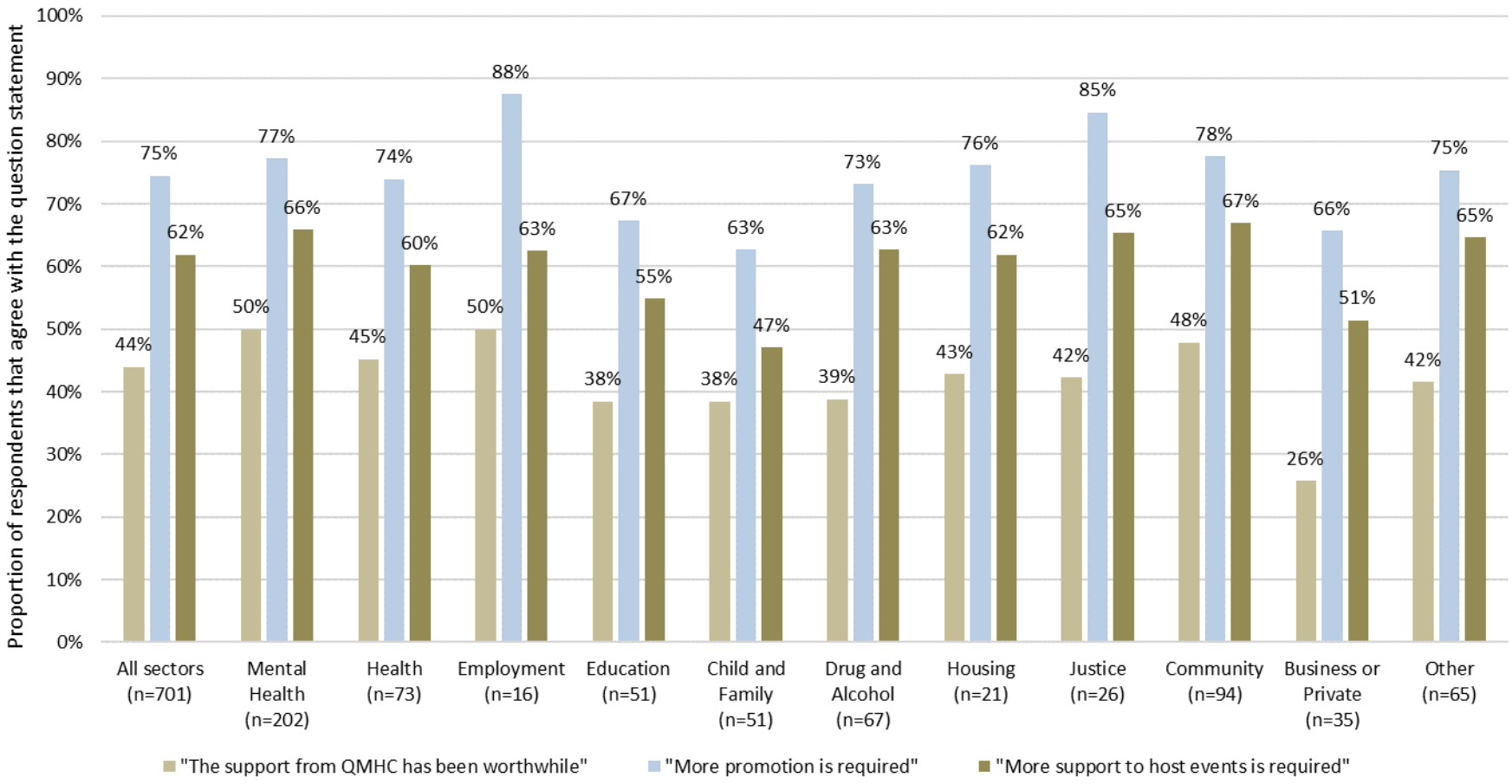


Figure 39: "Please rate your agreement or disagreement with the following statements regarding World Suicide Prevention Day" - by sector



4.4.3.1 Summary

In the 2015/16 period, the QMHC's work under this KRA focused on completing the action plans for alcohol and other drugs, suicide prevention and promotion, prevention and early intervention. The majority of respondents had at least heard about the documents, however, less than a third had received and read the documents. This may be due to the fact that the plans were relatively new at the time of the 2016 survey release.

The qualitative feedback on the action plans was mixed, with some stakeholders seeing them as a positive step toward driving reform, while in at least one case it was felt that they may create an additional layer of complexity to addressing already complex areas.

At the overall level, there was an increase in the proportion of respondents that agreed the QMHC's promotion and awareness work is increasing awareness and reducing stigma and discrimination.

When asked about the specific benefits of the QMHC's promotion and awareness work, the majority of respondents agreed that the activities were relevant and likely to benefit people with mental health or alcohol or other drug issues, those impacted by suicide and influence changes in policy and practice.

4.4.4 Systemic Governance

Aside from its role in strengthening state-wide 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
- Enhance the engagement of consumers, families and carers to 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 five occasions over the 2015/16 period to:

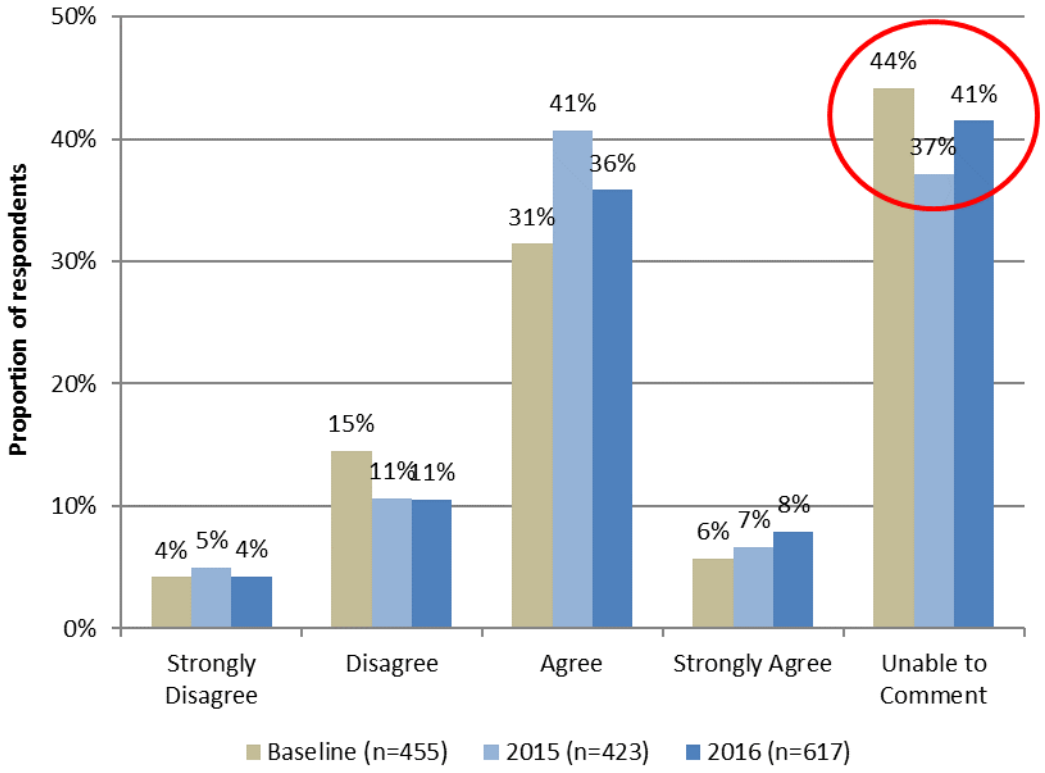
- provide input into research, evaluation and planning initiatives
- provide comment on emerging or immediate issues arising such as training and support for consumers and carers working in the health system, improving employment outcomes for people with mental health issues and delivering better outcomes for people with mental health issues involved with police and the criminal justice system
- Identify gaps in service provision and support for Queenslanders with mental health issues or issues with problematic alcohol or other drugs use
- consider the impact of system-wide changes on people experiencing mental health issues or problematic alcohol or other drugs use such as the National Disability Insurance Scheme

> *"We have not seen any outcomes that are attributable to the Commission or the Advisory Board"*
>
> - *2016 Survey respondent*

The largest proportion of 2016 survey respondents (44%) agreed that the MHDAC is providing effective advice to drive appropriate reform (Figure 40). This represents 4% fewer respondents than in 2015. However, consistent with previous surveys, a large proportion (41%) still indicated being "unable to comment".

Recommendation 13 of the 2015 Evaluation Survey suggested that the QMHC publish the MHDAC's Terms of Reference to its website to assist stakeholders in understanding the role of the MHDAC. While this was completed, the latest survey results suggest there is still a need to improve understanding of the MHDAC's role, activities and how it interfaces with the Commission and the broader mental health, alcohol and other drugs system.

Figure 40: "*The Queensland Mental Health and Drug Advisory Council is providing effective advice to drive appropriate reform*"



The 2015/16 year represented a significant change for the MHDAC with the resignation of the Chair and a number of other members' initial terms expiring in the first part of the year. The new Chair and ten new members were not appointed until May 2016. Notably, the new members include representation from CALD, ATSI and rural and remote communities, which are all areas that in prior years have been identified as areas that required stronger engagement by the QMHC.

The MHDAC's role over the next phase of the Commission's maturity will be key to ensuring the Commission continues to undertake relevant work and progress the various agendas in the mental health and alcohol and other drugs space. Similarly, for the MHDAC to perform its functions effectively, it must increase promotion of its collective activities and that of its members to address the gap in stakeholder understanding of the group's role in supporting the Commission.

Management comment:

With a substantial number of vacancies in membership for almost half the year, the profile of the Council has necessarily been low in 2015/16 and it is not surprising that many respondents as shown in Figure 41 were unable to comment on the effectiveness of its advice.

4.4.4.2 Consumers, families and carers 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.

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.

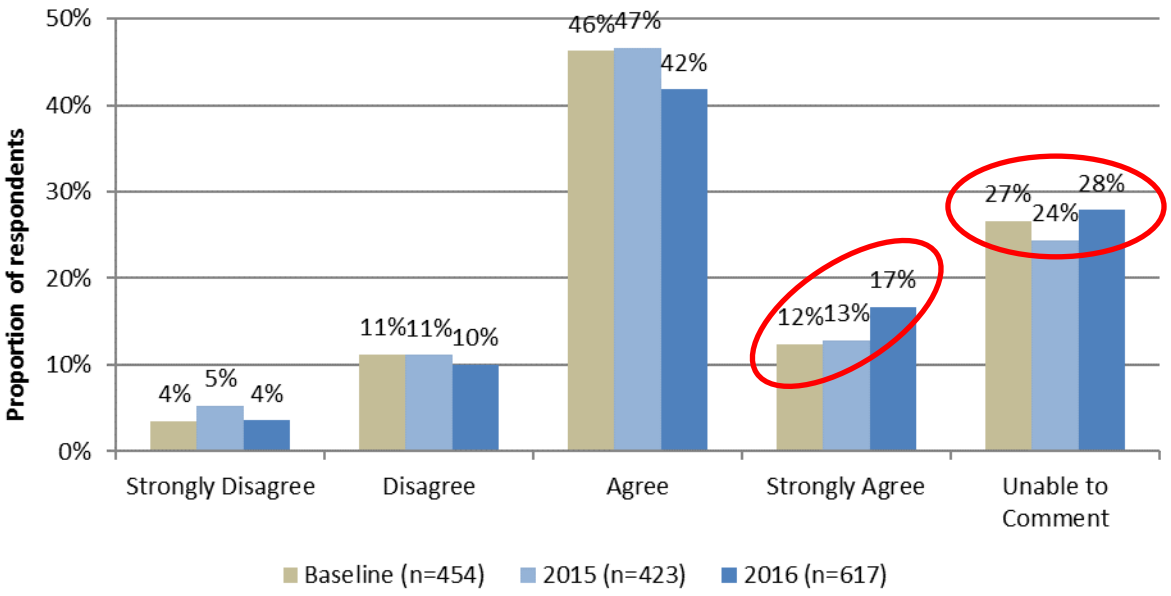
Approximately 60% of respondents across all three surveys (baseline, 2015 and 2016) agreed that the QMHC is utilising the views of people with lived experience, their families, carers and support people to inform planning and decision making (Figure 41). Encouragingly, in the latest year, while a similar overall proportion of respondents agreed (59%), there has been shift in the proportion that reported "Strongly Agree" (2016: 17% vs 2015: 13%) compared to "Agree" (2016: 42% vs 2015: 47%).

> *"Working well by being inclusive of consumers and carers"*
>
> - *2016 Survey respondent*

Similar to prior years, a large proportion of respondents to this question indicated being 'unable to comment' in 2016 (28%). This suggests 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"***



4.4.4.3 Summary

While the slight majority of respondents agreed that Queensland Mental Health and Drug Advisory Council (QMHDAC) is providing effective advice to drive appropriate reform, consistent with prior years a large proportion (~40%) of 2016 respondents reported being "Unable to Comment" suggesting a continuing opportunity for the QMHDAC to increase its profile and understanding of its role amongst stakeholders.

In the 2016 year, there was an increase proportion of respondents agreeing that the QMHC is utilising the views of people with lived experience, their families, carers and support people to inform planning and decision making.

This view was largely echoed in free text responses provided in the survey, suggesting that the QMHC's efforts in to improve engagement with these groups is beginning to create tangible benefits.

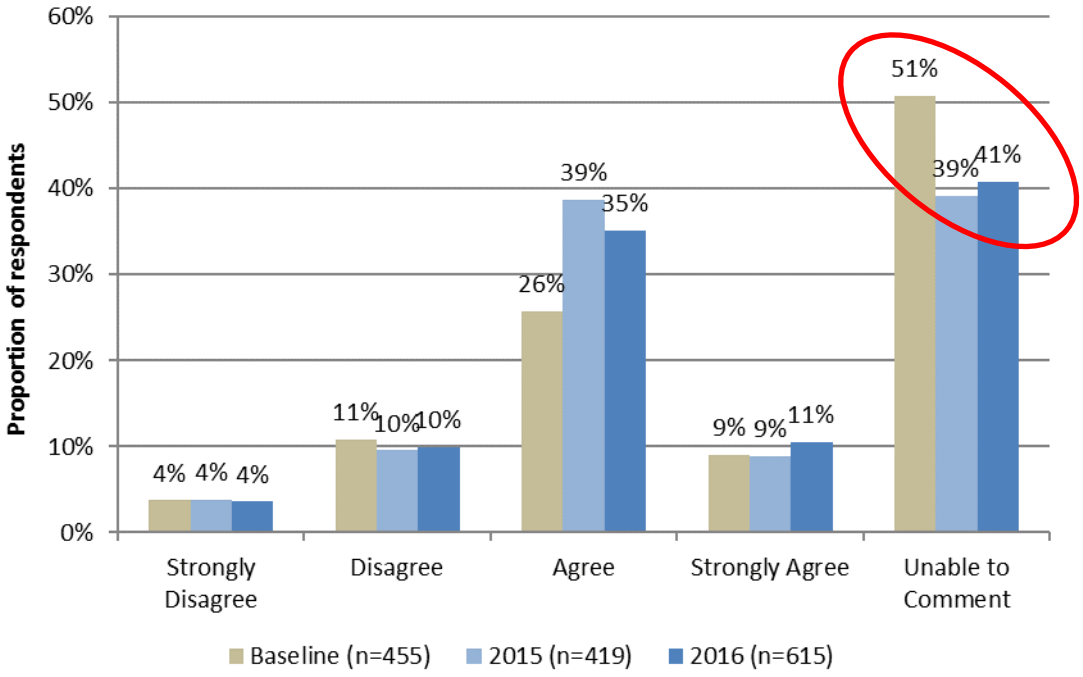
4.4.5 Sustainability of reforms

At the Baseline Survey, less than half of respondents 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

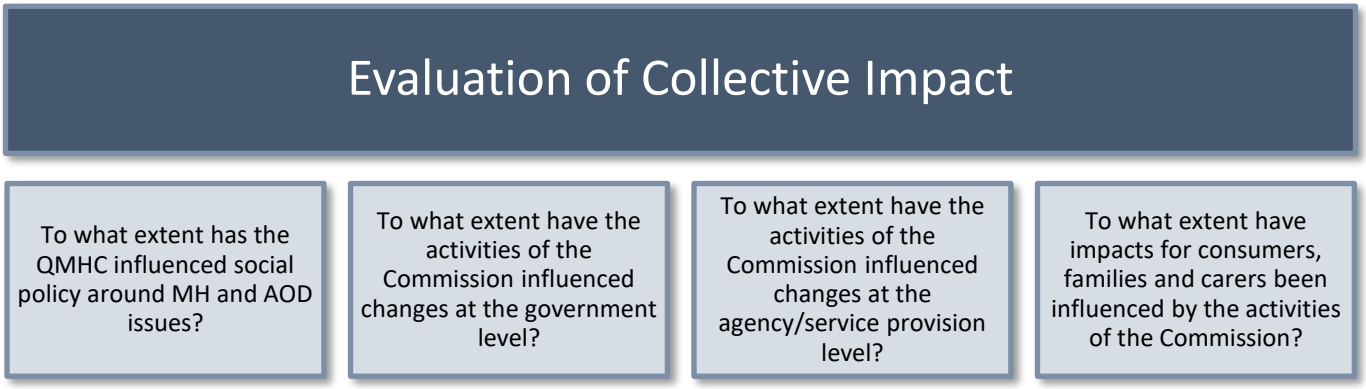
given that at the time of the Baseline Survey the QMHC was still in the early stages of its inception. A year on, the 2015 survey results indicated that more stakeholders (48% of respondents) were starting to shift toward a view that suggests a greater degree of comfort with the sustainability of reform (13% higher than the Baseline). In the 2016 year there was a slight decline in total proportion of stakeholders agreeing the reforms the QMHC is driving will be sustainable in the longer term (46%). However, while a smaller proportion responded as 'Agree' (2016: 35% vs 2015: 39%) a slightly higher proportion in the same year reported 'Strongly Agree' (2016: 11% vs 2015: 9%).

While there was a 10% decrease in the proportion of respondents reporting being "Unable to Comment" between 2014 and 2016, this group was still the highest proportion of all respondents (41%). Per previous years, it may be still too early for a large proportion of stakeholders to tell whether the reforms will be sustainable or not. Again, this may not be surprising, taking into account that most stakeholders anticipated over five years to be required before the wider impacts of the Strategic Plan are observed (Figure 33).

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



4.5 Collective Impact



4.5.1 Key Findings

During the 2015/16 year, the Commission released the first annual Performance Indicators Report which articulates a series of indicators for each of the six long term Outcomes defined in the Strategic Plan:

1. A population with good mental health and wellbeing
2. Reduced stigma and discrimination
3. Reduced avoidable harm
4. People living with mental health difficulties or issues related to substance use have lives with purpose
5. People living with mental illness and substance use disorders have better physical and oral health and live longer
6. People living with mental illness and substance use disorders have positive experiences of their support care and treatment.

Monitoring the defined indicators over time will contribute to an understanding of whether the Strategic Plan Outcomes are being achieved and, by extension, whether Collective Impact is being achieved.

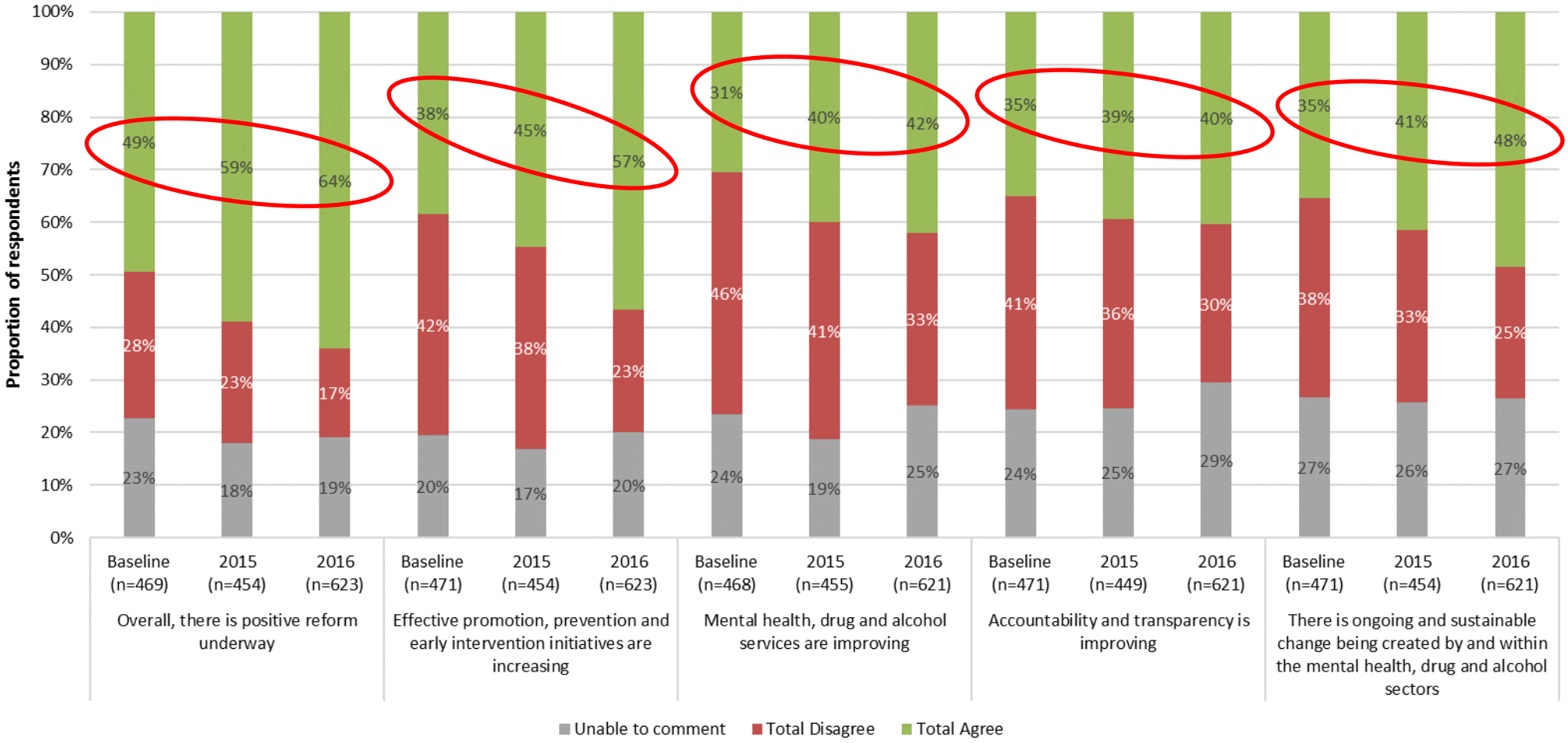
The key achievements in the 2015/16 year were the finalisation and release of the action plans for suicide prevention, alcohol and drugs and awareness, prevention and early intervention.

Over the last three survey years there has been progressive improvement in each of the indicators regarding overall system changes since inception of the QMHC (Figure 43). In the 2016 year the majority of respondents (64%) agreed that overall there was positive reform underway. This was an improvement over the Baseline where just under half of respondents held the same view.

The greatest improvement was seen in respondents agreeing that effective promotion, awareness and early interventions are increasing where an additional 19% of respondents between the Baseline and 2016 survey agreed with the statement (2016: 57% vs 2014: 38%). Modest improvement was seen in the proportion of respondents agreeing that the mental health, drug and alcohol services are improving. This may not be surprising given that the timeframes for observing impact of the QMHC's activities at the service level are likely to be longer.

The smallest improvement (an additional 5% of respondents between Baseline and 2016) was recorded for respondents agreeing that accountability and transparency are improving. Some of the activities the QMHC has underway and planned for future years should go some way to addressing this. Notably, the annual performance indicators report should assist in highlighting areas for improvement and transparency and consistency in how system performance is measured. In addition, the Commission's work to review mental health and AOD funding in health should improve transparency of spending on mental health and AOD services and drive improved accountability for public spending.

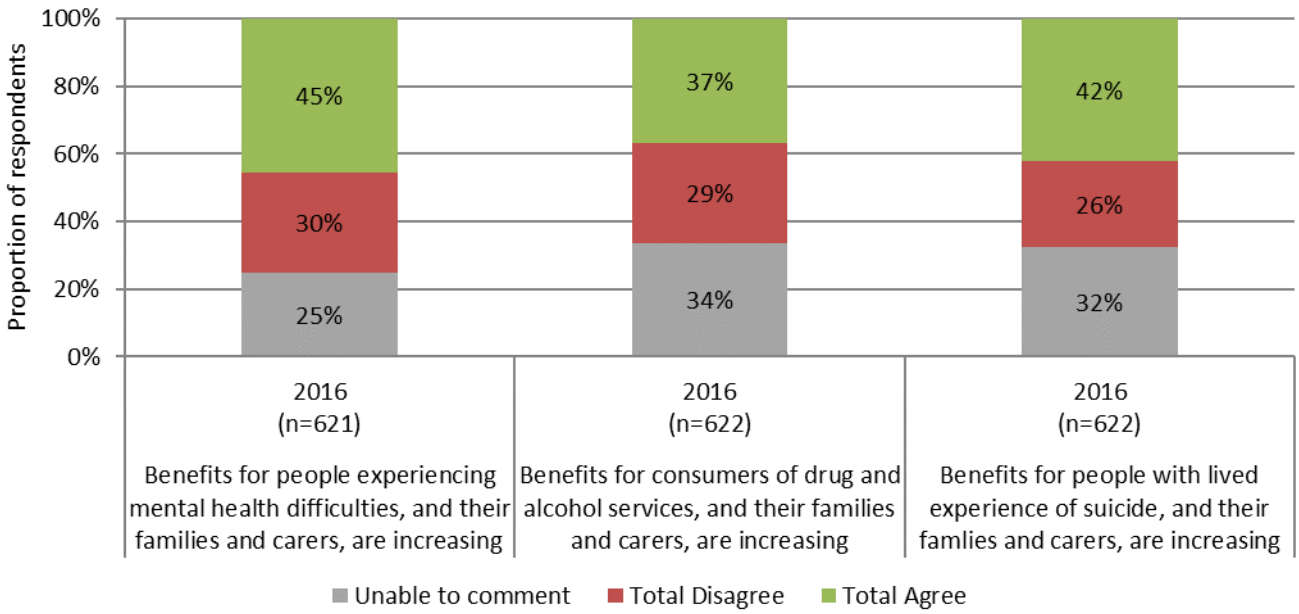
Figure 43: Progress on overall changes in the Mental Health, Drug and Alcohol system



A set of questions were included in the 2016 survey to explore stakeholder views on whether overall benefits for people with lived experience are increasing. Since these were a new set of questions for the 2016 survey no comparison with historic data is possible at this time. In all cases, the largest portion of respondents agreed, however, this was less than half of all respondents (Figure 44). A smaller proportion of respondents agreed that benefits for consumers of drug and alcohol services, their families and carers are increasing (37%) compared to benefits for people experiencing mental health difficulties (45%) and people with lived experience of suicide (42%).

These new indicators will be useful in measuring shifts in these views following the release in 2015/16 of the action plans for alcohol and other drugs and suicide prevention.

Figure 44: Overall benefits for people with lived experience, their families and carers



4.5.2 Summary

While still too early in many cases to measure collective impacts from the QMHC's work, at the overall level it is encouraging to see an increasing proportion of respondents reporting that overall positive reform is underway.

In terms of the overall benefits for people with lived experience of mental health difficulties, alcohol and other drugs issues and people impacted by suicide, the minority in all cases responded in the positive. While these are the ultimate measures of success for a high-performing mental health, drug and alcohol system, benefits at these levels are likely to require a longer period to achieve. Therefore, these indicators should be monitored carefully over time to identify future impacts.

Appendix A – 2016 Survey questions

QMHC Evaluation Annual Survey - 2016

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 annually to identify any changes in stakeholder views over time.

This is the third annual survey. The actions arising in response to the Baseline (2014) and 2015 surveys are on the QMHC 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

QMHC Evaluation Annual Survey - 2016

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)

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QMHC Evaluation Annual Survey - 2016

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.	○	○	○	○	○

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QMHC Evaluation Annual Survey - 2016

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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QMHC Evaluation Annual Survey - 2016

Understanding of the QMHC

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.

8. 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.	○	○	○	○	○

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Understanding of the QMHC

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

	Strongly Disagree	Disagree	Agree	Strongly Agree	Unable to comment
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 benefit from the work of the QMHC.	○	○	○	○	○

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QMHC Evaluation Annual Survey - 2016

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
- ☐ Facebook
- ☐ 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

QMHC Evaluation Annual Survey - 2016

QMHC Collaboration and Consultation

Collaboration can be considered as a process with progressive stages. This section aims to understand the current and desired level of collaboration, if any, between your organisation and the QMHC.

11. Please select the statement that best describes the level of collaboration between your organisation and the QMHC:

- ◯ Unable to comment
- ◯ No current collaboration
- ◯ We exchange information for mutual benefit **(Networking)**
- ◯ We exchange information for mutual benefit and we have altered our activities for common purpose/s **(Co-ordinating)**
- ◯ We exchange information, alter our activities and share resources for mutual benefit and for common purpose/s **(Co-operating)**
- ◯ We exchange information, alter our activities, share resources and work to enhance each other's capacity for mutual benefit and for common purpose/s **(Collaborating)**

12. Please rate agreement or disagreement with the following statements:

	Strongly Disagree	Disagree	Agree	Strongly Agree	Unable to Comment	Not applicable
The current level of collaboration between my organisation and the QMHC is sufficient to achieve my organisation's existing strategic goals	◯	◯	◯	◯	◯	◯
Collaboration with the QMHC will be essential to achieving my organisation's future strategic goals	◯	◯	◯	◯	◯	◯

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QMHC Evaluation Annual Survey - 2016

QMHC Collaboration and Consultation

13. 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).	○	○	○	○	○
The work of the QMHC has improved co-ordination of services for people with multiple concurrent issues (e.g. mental health, substance misuse, disability, chronic disease, homelessness, and/or involvement with the criminal justice system).	○	○	○	○	○

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About the Queensland Mental Health, Drug and Alcohol Strategic Plan

14. 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
○	○	○	○	○

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QMHC Evaluation Annual Survey - 2016

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
The Strategic Plan has influenced activities and decisions made within my organisation.	○	○	○	○	○
My organisation is participating in implementing the Strategic Plan.	○	○	○	○	○
I am personally participating 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.	○	○	○	○	○

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QMHC Evaluation Annual Survey - 2016

About the Queensland Mental Health, Drug and Alcohol Strategic Plan

16. 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

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QMHC Functions

17. 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.	○	○	○	○	○

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Focus on : QMHC Promotion and Awareness function

A key role of the QMHC is to facilitate and promote awareness, prevention and early intervention by supporting government and non-government stakeholders in undertaking effective action.

18. Regarding the overall activities that the QMHC undertakes or commissions with respect to Promotion, Awareness and Early Intervention, please rate your agreement or disagreement with the following statements:

	Strongly Disagree	Disagree	Agree	Strongly Agree	Unable to comment
The activities are **relevant to current issues and trends** in mental health and wellbeing	○	○	○	○	○
The activities help to **increase awareness and understanding** about mental health and wellbeing	○	○	○	○	○
The activities help to **reduce stigma and discrimination** in relation to mental health and alcohol and other drug issues	○	○	○	○	○
The activities support and **promote social inclusion and recovery** of people with mental illness of who misuse substances	○	○	○	○	○
The activities help to **promote and facilitate sharing of knowledge** about mental health and wellbeing	○	○	○	○	○
The activities are likely to **contribute to changes in policy, practice or service delivery** in **mental health**	○	○	○	○	○

	Strongly Disagree	Disagree	Agree	Strongly Agree	Unable to comment
The activities are likely to **contribute to changes in policy, practice or service delivery** in **alcohol and other drugs**	○	○	○	○	○
The activities are likely to **benefit people living with mental health difficulties**	○	○	○	○	○
The activities are likely to **benefit people adversely affected by alcohol and other drugs**	○	○	○	○	○
The activities are likely to **benefit people impacted by suicide**	○	○	○	○	○
The activities are likely to **benefit the mental health and wellbeing of all Queenslanders**.	○	○	○	○	○

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QMHC Evaluation Annual Survey - 2016

Focus on : QMHC Promotion and Awareness Function

19. Please indicate your level of awareness of the QMHC's activities with respect to the following specific initiatives:

	Not aware	Heard About	Received document/s but did not read	Received and read document/s	Involved in development of document
Early Action: Queensland Promotion, Prevention and Early Intervention	○	○	○	○	○
Suicide Action Plan	○	○	○	○	○
Alcohol and Other Drugs Action Plan	○	○	○	○	○
Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Action Plan	○	○	○	○	○
Rural and Remote Mental Health and Wellbeing Action plan	○	○	○	○	○
Performance Indicators for Mental Health and Wellbeing	○	○	○	○	○

20. Please rate your agreement or disagreement with the following statements regarding**Mental Health Week**

	Strongly Disagree	Disagree	Agree	Strongly Agree	Unable to Comment
The support from QMHC has been worthwhile	○	○	○	○	○
More promotion is required	○	○	○	○	○
More support to host events is required	○	○	○	○	○

21. Please rate your agreement or disagreement with the following statements regarding**World Suicide Prevention Day**

	Strongly Disagree	Disagree	Agree	Strongly Agree	Unable to Comment
The support from QMHC has been worthwhile	○	○	○	○	○
More promotion is required	○	○	○	○	○
More support to host events is required	○	○	○	○	○

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QMHC Evaluation Annual Survey - 2016

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.

22. 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	○	○	○	○	○
Benefits for people experiencing mental health difficulties, and their families and carers, are increasing	○	○	○	○	○
Benefits for consumers of drug and alcohol services, and their families and carers, are increasing	○	○	○	○	○
Benefits for people with lived experience of suicide, and their famlies and carers, are increasing	○	○	○	○	○
There is ongoing and sustainable change being created by and within the mental health, drug and alcohol sectors	○	○	○	○	○

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QMHC Evaluation Annual Survey - 2016

QMHC Successes and Suggestions

23. In what ways is the QMHC working well?

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

25. 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?

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QMHC Evaluation Annual Survey - 2016

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.

* 26. 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
- [ ] Other (please specify)

- [ ] Federal or Local Government Employee
- [ ] Queensland State Government Employee
- [ ] QLD Mental Health and Drug Advisory Council Member
- [ ] Media representative
- [ ] University academic
- [ ] International partner
- [ ] Politician or political advisor

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QMHC Evaluation Annual Survey - 2016

About You

27. If you have indicated that you are a Queensland State Government Employee, please tell us which government area you work for primarily:

- ◯ Not applicable
- ◯ Department of Health (including eHealth Queensland and Health Support Services)
- ◯ Department of Aboriginal and Torres Strait Islander Partnerships
- ◯ Department of Communities, Child Safety and Disability Services
- ◯ Department of Education and Training
- ◯ Department of Housing and Public Works
- ◯ Department of Justice and Attorney-General
- ◯ Department of Agriculture and Fisheries
- ◯ Department of Natural Resources and Mines
- ◯ Department of Premier and Cabinet
- ◯ Queensland Police Service
- ◯ Queensland Ambulance Services
- ◯ Queensland Treasury
- ◯ Public Service Commission
- ◯ Legal Aid Queensland
- ◯ Office of the Health Ombudsman
- ◯ Anti-Discrimination Commission Queensland
- ◯ Queensland Family and Child Commission
- ◯ Hospital or Health Service
- ◯ Other (please specify)

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QMHC Evaluation Annual Survey - 2016

About You

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

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

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QMHC Evaluation Annual Survey - 2016

About You

29. Please indicate your current role.

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

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QMHC Evaluation Annual Survey - 2016

About You

30. 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

31. Please indicate your gender

- ◯ Male
- ◯ Female
- ◯ Transgender or intersex

32. 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

* 33. Please provide your postcode

Postcode

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QMHC Evaluation Annual Survey - 2016

Final comments

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