MEMORANDUM OF UNDERSTANDING

BETWEEN

AUSTRALIAN MENTAL HEALTH COMMISSIONS AND THE NEW ZEALAND MENTAL HEALTH COMMISSIONER

May 2014

Australian Government
National Mental Health Commission

Mental Health Commission
of New South Wales

Queensland Government
Queensland Mental Health Commission

Government of Western Australia
Mental Health Commission

Health & Disability Commissioner
Te Toihau Hauora, Hauātanga

This Memorandum of Understanding is made between

the National Mental Health Commission, Australia

AND

the Mental Health Commission of New South Wales, Australia

AND

the Queensland Mental Health Commission, Australia

AND

the Western Australia Mental Health Commission, Australia

AND

the Office of the Health and Disability Commissioner, represented by the Mental Health Commissioner, New Zealand

Date of signing: May 2014

A. Background

A1. Australia and New Zealand have a long history of collaboration and commitments to mental health reform. Mental Health Commissions have been established in the last decade – with different operating and reporting structures and responsibilities – but with a common purpose: to improve the mental health and wellbeing of the population.

A2. Commissions and Commissioners play an independent role in: representing the needs and aspirations of people with lived experience of mental health problems and their families, whānau, carers and other supporters; setting reform visions and strategies; catalysing and influencing system and behavioural change; improving accountability; and measuring progress and outcomes.

> The New Zealand Mental Health Commission was established in April 1998 and led a major programme of mental health and addiction service development. In 2013 the Commission was disestablished and **the New Zealand Mental Health Commissioner** joined the Office of the Health and Disability Commissioner with a statutory mandate to monitor the implementation of the national mental health and addiction strategy, and to advocate for systemic improvement.

The Government of Western Australia set up Australia's first commission in March 2010. The **Western Australia Mental Health Commission** provides leadership and support in a new approach to the delivery of mental health services in that state. It is also the purchaser of all State funded specialist mental health services in Western Australia.

The **National Mental Health Commission** was established by the Australian Government as an independent executive agency in January 2012 to improve accountability and transparency through independent reports and advice and to drive positive change at the national level.

The **Mental Health Commission of New South Wales** was established in July 2012 under the *Mental Health Commission Act 2012* to monitor, review and improve the mental health system and the mental health and well-being of the people of NSW.

The **Queensland Mental Health Commission** was established on 1 July 2013 as a statutory body under the *Queensland Mental Health Commission Act 2013 to* play a key role in improving mental health and minimising the impact of substance misuse in Queensland communities.

A3. Australian and New Zealand Commissioners have met several times since 2012 and in March 2013 all endorsed *The Sydney Declaration*[1] which outlines opportunities for collaboration. This Memorandum of Understanding (MoU) formalises a network of commissions across Australia and New Zealand, to align and coordinate effort around shared priorities, clarify roles and build common approaches.

A4. Collaboration between Commissions and Commissioners will help encourage sector collaboration, build consensus and enable the voices and experiences of people living with mental health problems, their families, whānau, carers and supporters, to genuinely inform policy and drive system improvements.

[1] The Sydney Declaration, March 2013, http://www.mentalhealthcommission.gov.au/our-work/the-sydney-declaration.aspx

MEMORANDUM OF UNDERSTANDING

1. The parties to this MoU

1.1 The parties to this MoU are the:

- National Mental Health Commission, Australia
- Mental Health Commission of New South Wales, Australia
- Queensland Mental Health Commission, Australia
- Western Australia Mental Health Commission, Australia
- Mental Health Commissioner, New Zealand

Further detail about each of the parties is in Schedule 1 to this MoU.

2. Purpose

2.1 The purpose of this MoU is to set out the commitment of all parties for a collaborative relationship, which recognises the parties' complementary roles and mutual interest in improving outcomes for people experiencing mental health problems and addictions, and preventing suicide.

2.2 Specifically, the MoU provides a framework and sets out the mechanisms for the parties to work together towards improving outcomes while pursuing their own interests and priorities.

3. Commitment

3.1 This MoU records the parties' commitment to:

a) actively seek out opportunities for joint effort, co-production and cross-promotion of work, informed by the lived experience of those experiencing mental health issues and their families, whānau, carers and support people, and service providers and professional groups working in the various sectors that support people to live contributing lives

b) work together to set a standard for others to follow that enshrines the inclusion of people with lived experience of mental health issues, their families, whānau, carers and support people in policy design, decision making, planning, implementation and service delivery

c) operate in a manner that encourages broader partnership with individuals and organisations that are not direct parties to this MoU

d) actively seek to avoid duplication of effort and to leverage the parties' respective resources, for example by accessing existing participation and engagement structures wherever practicable

e) communicate openly and share information, data, research, policies and reports with each other for the purposes of this MoU (except where legal obligations prevent this)

f) utilise the MoU as a reference point for each organisation, and to signal to the broader community our efforts to work together effectively to achieve positive outcomes for our communities, and

g) address any competing priorities openly and constructively.

3.2 The parties have identified specific areas and activities of shared interest, collaboration and action which are set out in Schedule 2. These may be amended from time to time to reflect emerging or new priorities.

4. Structures for collaboration and communication

4.1 Effective communication will assist in realising the commitments in this MoU. In addition to the broad commitment to open communication at all levels of each organisation, the following mechanisms will further strengthen collaboration between the parties:

a) Sharing of work plans, and details of events (such as launches and consultations) and other activities (such as research or other projects)

b) Including the other parties in distribution and invitation lists, where appropriate

c) Quarterly meetings between the signatory (or the person occupying the position of the signatory at the time) of each party to discuss areas of mutual interest. These meetings may be held face to face where appropriate, or by videoconference or teleconference to ensure effective use of resources. One of these meetings each year will review the implementation of this MoU. Each Commission CEO will be responsible for reporting back to their full Commission or broader governance structures as appropriate.

d) Meetings between the CEOs, Commission Chairs and potentially other Commissioners to discuss strategic issues of mutual interest. These meeting will be scheduled as required and as resources allow but will occur at least once every two years. Other guests including Chairs of Statutory Advisory Councils or experts may be invited.

4.2 Outcomes of these meetings will be documented and available on the websites of all parties.

5. Resourcing and Financial relationship

5.1 The commitments of this MoU are not dependent upon any financial relationship (for example the commissioning of research or services) that might be negotiated separately. The parties recognise that activities and commitments under this MoU will have to consider the relative size and resource capacity of each party.

5.2 Costs associated with meeting for the purposes of this MoU, including travel, will be met by each respective party, unless agreed otherwise.

5.3 The parties will agree and rotate each year responsibility for organising and providing secretariat support to the quarterly meetings of the signatories of each party. The parties will also agree and rotate responsibility for organising and providing secretariat support to the full meetings of Commissions.

6. Legal effect

6.1 This MoU is not legally binding and does not create a legal relationship between the parties.

6.2 The commitments of this MOU do not substitute or interfere with any legal responsibilities and obligations of an individual party or between parties. It does not require either party to act in any way contrary to their statutory responsibilities or contractual obligations with other third parties.

7. Non-exclusive Relationship

7.1 The parties acknowledge that this MoU does not constitute an exclusive relationship and any party may develop other relationships as appropriate.

8. Representations

8.1 Each party agrees that they will not make any statement on the others' behalf to a third party without the express authorisation of the relevant party or parties.

9. Disclosure of information

9.1 Subject to relevant legislation, neither party shall, without the prior written approval of the other party, disclose to any person other than personnel of that party, any material which is the property of the other party. The parties shall agree in writing to the terms of any such release.

9.2 Each party agrees that for corporate governance requirements, the other party may report details of this MoU on its website and in its annual report.

10. Ownership of existing material

10.1 Ownership of any existing material, including Intellectual Property rights in the existing material, of any party will not be affected by virtue of the existence of this MOU.

11. Dispute Resolution

11.1 The parties will act at all times in good faith and with the goal of preserving their relationship. However, in the event of a dispute the parties agree to the following process:

a) in the first instance the agreed representatives of the parties will meet and attempt to resolve the dispute
b) if following 11.1(a) the dispute is not resolved, the parties will engage in mediation through an agreed process.

12. Term

12.1 This MoU:

a) commences upon signing by all parties
b) is valid for a period of three years, after which it will be terminated, or reviewed and renewed
c) may be terminated by the mutual agreement of the parties, or by one or more party giving three months' written notice of termination to the other parties.

13. Review and Variation

13.1 This MoU records the parties' commitment to a long-term relationship. The parties acknowledge that over time the nature and focus of the relationship will evolve to reflect changing circumstances. Therefore, the parties will review this MoU every three years, or otherwise as mutually agreed. The parties may at any time, by mutual agreement, vary this MoU and/or the Schedule(s) to this MoU.

13.2 Additional signatories may be included with the consent of all parties.

SIGNED as a Memorandum of Understanding:

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Mr David Butt
Chief Executive Officer and Commissioner (ex-officio)
National Mental Health Commission

Date: 23/06/2014

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Mr John Feneley
Commissioner
Mental Health Commission of New South Wales

Date: 12/05/2014

Dr Lesley van Schoubroeck
Commissioner
Queensland Mental Health Commission

Date: 03/07/2014

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Mr Timothy Marney
Commissioner
Western Australian Mental Health Commission

Date: 26/ 5/ 2014

Dr Lynne Lane
New Zealand Mental Health Commissioner
Office of the Health and Disability Commissioner

Date: 12/06/2014

SCHEDULE 1

Parties to the Memorandum of Understanding between Australian Mental Health Commissions and the New Zealand Mental Health Commissioner

National Mental Health Commission, Australia

http://www.mentalhealthcommission.gov.au/

The National Mental Health Commission (NMHC) was established on 1 January 2012 by order of the Governor-General as an independent executive agency under the *Public Service Act 1999* and operates in accordance with the *Financial Management and Accountability Act 1997*. The NMHC reports to the Australian Government Minister for Health.

The Chair and Commissioners, who bring a range of expertise and perspectives, reflect the evidence they gather from the community, research and data. They are committed to giving an independent view of system performance and a voice to the experiences of people living with mental health difficulties or suicide risk and their families and support people. The CEO is an ex-officio Commissioner. Commissioners are supported by a small team of up to 14 staff.

The NMHC takes a whole-of-life and cross-government approach to its work, based on a 'contributing life' framework:

> *A contributing life means a fulfilling life enriched with close connections to family and friends, and experiencing good health and wellbeing to allow those connections to be enjoyed. It means having something to do each day that provides meaning and purpose, whether this is a job, supporting others or volunteering. It means having a home and being free from financial stress and uncertainty.*

As such the NMHC looks at the wide range of policy, programs and supports that promote good mental health, prevent mental health difficulties and suicide and aid recovery using three key strategies:

Reporting: We produce an annual National Report Card on Mental Health and Suicide Prevention (the Report Card), informing Australians of where we are doing well and where we need to do better in mental health. As well as looking at the facts and figures, the report card tells the real and everyday experiences of Australians.

Advising: We use reports, relationships and influence to give honest and independent advice on where and how Australia can better support people with a lived experience of mental health difficulties and their families and support people. The NMHC has been tasked

by the new Australian Government to conduct a comprehensive review of the mental health system.

Collaborating: We work with others across all sectors to influence positive change. We also encourage more collaborative ways of working, by helping to bring people together who have the same goals and the same vision.

We do not get involved in individual cases or advocate for individual people or groups. Instead we are an advocate for system improvement and better accountability. We are not a fund holding body. We do not provide services, grants or funding for major projects or campaigns.

By reporting, advising and collaborating we will help transform systems and promote change, so that all Australians achieve the best possible mental health and wellbeing.

Mental Health Commission of New South Wales

http://www.nswmentalhealthcommission.com.au

The Mental Health Commission of New South Wales is an independent body established to improve the mental health and wellbeing of the people of NSW. It is not a service provider or fund holder. The Commission works to drive reform that benefits people who experience mental illness and their families and carers.

The Commission is working with the community towards sustained improvement in the support offered to people who experience mental illness and in their access to employment, education, housing, justice and general health care.

As drivers of reform, we are:

- developing a whole-of-government draft Strategic Plan for Mental Health in NSW which aims to support people who experience mental illness, their families and their carers to live full and rewarding lives
- monitoring and reporting on its implementation
- reviewing, evaluating, reporting on and advising on services and programs
- undertaking and commissioning research and policy development
- promoting innovative programs and sharing knowledge about good practices in mental health promotion, early detection and care.

Queensland Mental Health Commission

http://www.qmhc.qld.gov.au

The Queensland Mental Health Commission (QMHC) was established on 1 July 2013 as a statutory body under the *Queensland Mental Health Commission Act 2013* and reports directly to the Minister for Health.

Its key charter is to:

- Drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health, drug and alcohol system within Queensland.
- Provide strategic leadership for a united, cross-sectoral approach aimed at fostering contributing lives for Queenslanders living with, or vulnerable to, mental illness or substance misuse

QMHC is a lean, focused, independent entity (10 Staff) whose governance includes a Mental Health and Drug Advisory Council, established to provide advice and/or make recommendations to the Commissioner on mental health or substance misuse issue. Advisory Council membership reflects the diversity of the Queensland community and the mental health sector.

We are developing a whole-of-government strategic plan that seeks to align with the National mental health objectives and the specific needs of Queensland.. With the Plan's strategic priorities as its focus QMHC will:

- work to ensure the needs of people living with, or vulnerable to, mental illness or substance misuse are a core focus of government and non-government policy and program planning and delivery
- undertake systemic advocacy regarding issues affecting the treatment, support and inclusion of people living with, or vulnerable to, mental illness or substance misuse
- lead coordinated action by government, non-government and community agencies providing mental health or drug and alcohol services or other human services to people with, or vulnerable to, mental illness or substance misuse
- drive best practice in the provision of mental health, drug and alcohol and broader human services to this cohort, including by supporting knowledge sharing, research, innovation and evidence-based policy and practice
- promote the mental health of Queenslanders, including by supporting prevention and early intervention initiatives and enhancing the community awareness of mental health, mental illness and substance misuse related harm.

Western Australian Mental Health Commission

http://www.mentalhealth.wa.gov.au/Homepage.aspx

The Western Australia Mental Health Commission (WAMHC) provides leadership and support in a new approach to the delivery of mental health services.

The establishment of the WAMHC, the first in Australia, was a key step in creating a modern effective mental health system that has the individual and their recovery as its focus. The WAMHC was established as a Government agency in March 2010 with responsibility for strategic policy, planning, purchasing and monitoring of these services. It promotes public awareness of mental wellbeing and will address stigma and discrimination affecting people with mental illness. It reports to the Minister for Mental Health.

The WAMHC's vision is:

A Western Australia where everyone works together to encourage and support people who experience mental health problems and /or mental illness to stay in the community, out of hospital and live a meaningful life.

The WAMHC's work is underpinned by the Western Australian Government's 10 year strategic policy *Mental Health 2020: making it personal and everybody's business.*

The Mental Health Advisory Council provides independent strategic advice to the WAMHC.

As steward of the public investment in mental health, the WAMHC has a duty to provide direct funding for services and supports that best meet the need of consumers, their families and carers.

The WAMHC's current functions include:

- development and provision of mental health policy and advice to the government
- leading the implementation of the Western Australian Government's strategic policy *Mental Health 2020: making it everybody's business.*
- articulating key outcomes and determining the range of mental health services required for defined areas and populations across the state
- specifying activity levels, standards of care and determining resourcing required
- identifying appropriate service providers and benchmarks and establishing associated contracting arrangements with both government and non-government sectors
- providing grants, transfers and service contract arrangements
- ongoing performance monitoring and evaluation of key mental health programs in Western Australia
- ensuring effective accountability and governance systems are in place
- promoting social inclusion, public awareness and understanding of matters relating to the wellbeing of people with mental illness to address stigma and discrimination.

Office of the Health and Disability Commissioner, New Zealand, represented by the Mental Health Commissioner

http://www.hdc.org.nz

The Office of the Health and Disability Commissioner, New Zealand is represented under this MoU by the Mental Health Commissioner who is tasked with:

- monitoring and reporting on matters relating to the implementation of the national mental health strategy, and.
- advocating at all levels in the sector, including providing advice to the Minister of Health for the interests of people with mental health and/or addiction problems and their families/whānau generally (rather than for individuals or groups), while taking into account the interests of other stakeholders.

The Mental Health Commissioner is largely responsible for the performance of these functions under delegation from the Health and Disability Commissioner (HDC).

The Mental Health Commissioner provides independent advice to government on sector-wide issues and public policy relating to the mental health and addictions sector, and advocates for best practice on behalf of consumers and their families/whānau.

Specifically, the Mental Health Commissioner's role is to:

- foster key relationships nationally and internationally in order to encourage collaboration and advocate for evidence-based best practice
- support the Ministry of Health to develop a national monitoring framework in order to measure progress in achieving the goals in the national mental health and addiction strategy
- develop the HDCs own monitoring function which includes measuring the impact of systemic changes on consumer and family/whānau experience
- carry out a regular programme of visits around the country to hear from consumers, their families/whānau, practitioners, managers and other agencies involved in mental health and addictions such as schools, the Police etc.
- utilise intelligence gathered through HDCs monitoring functions to identify priority issues and advocate for systemic improvements.

May 2014

SCHEDULE 2

to the Memorandum of Understanding between Australian Mental Health Commissions and the New Zealand Mental Health Commissioner

Specific areas and projects of shared interest and collaboration

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In March 2013 the parties endorsed The Sydney Declaration[2] which supports action both together and locally in five priory areas.

Extracts from the Declaration and supporting actions follow.

Aboriginal, Torres Strait Islander and Māori mental health

We recognise Indigenous peoples as the first or original peoples of our countries, who have a longstanding and enduring relationship to the land. We recognise that colonisation negatively impacted on Indigenous cultures, communities and peoples, and that its legacy continues to affect their mental health and wellbeing today. We recognise and value the strength and resilience of Indigenous peoples and communities. Indigenous peoples share similar values regarding the importance of family and community as protective factors for social and emotional well-being. These values need to be inherent in mental health systems to help underpin holistic approaches to health, mental health and well-being for the benefit of all in our communities.

Together we commit to adopt the Wharerātā Declaration with its vision of Healthy Indigenous individuals, families and communities.
http://www.fnhma.ca/conference/2011/FNHMA%20English/Workshop%20L.pdf

We commit to the principles of partnership with Indigenous peoples and mental health leaders to achieve the vision of culturally accessible and competent mainstream mental health services for Indigenous individuals, families and communities, and to the development of Indigenous leaders in mental health to influence future systems change.

We uphold the principle of genuine partnership with Indigenous peoples to develop mental health programs, interventions and policy together, to increase the effectiveness for Indigenous peoples and as Indigenous leaders request, "nothing for us, without us".

We will advocate for cultural competence across all mental health professions as well as higher education curricula as a key quality improvement approach. In the development of cultural competence standards and future learning opportunities it is crucial to ensure Indigenous peoples play significant leadership roles.

We recognise the vital role of Indigenous leaders to advocate for holistic, cultural and community-based approaches in mental health. We support the on-going development of Indigenous leaders in mental health, so that they are able to influence change in systems which will benefit us all.

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[2] Ibid

As evidence of our commitment to Indigenous peoples mental health and well-being, we commit to:

Action 1: Include and value Indigenous perspectives and practice in our respective programmes of work.

Action 2: Advocate for and promote trauma-informed care approaches to strengthen mental health practice across all our communities.

Action 3: Contribute to the on-going development of Indigenous leaders in mental health by supporting Indigenous peoples to collaborate and learn from each other domestically and internationally (for example with and through the International Initiative for Mental Health Leadership (IIMHL)).[3]

Action 4: Impart knowledge from Indigenous communities on holistic approaches to health, mental health, social and emotional wellbeing.

Seclusion and restraint

We recognise that seclusion and restraint has been formed in part as a cultural practice across services and systems and is not based on evidence of effectiveness in caring for and supporting people with mental health difficulties and their families and supporters. We acknowledge the views of people with lived experience and recognise that seclusion and restraint can and does damage people, especially those who have experienced trauma. Seclusion and restraint practices can lead to further re-traumatisation and fear of accessing care, treatment and support.

We also recognise that families, carers, supporters and service providers are extremely concerned about the use of seclusion and restraint and the lack of information and response following the use of these practices. This underlines the need for reflective practice and continuing practice improvement.

The use of involuntary practices and specifically seclusion and restraint is a complex area and together we will work to bring an end to the practices of seclusion and restraint across our mental health systems. To help this, we commit to:

1. Sharing knowledge and experience, including how to implement models of good practice in ending seclusion and restraint practices.

2. Advocating for the engagement of people using services, their families and communities in the on-going development of services, particularly around working together to bring an end to seclusion and restraint.

3. Finding common definitions to facilitate improved data collection and indicators to report on seclusion and restraint to help measure the extent to which these practices are ending.

4. Supporting one another to bring about the changes needed to get evidence regarding improving patient safety and occupational health and safety issues that help underpin this work.

[3] http://www.iimhl.com/

5. Consider the need for possible legislative mechanisms to support bringing an end to seclusion and restraint practices.

As evidence of our commitment to helping to bring an end to the practices of seclusion and restraint, we agree to:

Action 5:	Show leadership in bringing an end to seclusion and restraint and raise this agenda as one for immediate change.
Action 6:	Identify and share practices, improvements and lessons learned.
Action 7:	Meet within the next three years on an international basis to review progress.

Work and mental health

We recognise that addressing the relationship between work and mental health has benefits for people with mental health difficulties, broader communities and economies.

The participation of people in meaningful work is a matter for governments, public services agencies, businesses large and small, NGO's and communities. The workplace can contribute to mental well-being and play an essential part in helping people and families attain their full potential in living a contributing and meaningful life.

It is also important to highlight that the health or harm created in workplaces can migrate into families, communities and society as a whole, and vice versa. Meaningful employment is a key component of recovery from significant mental health difficulties and challenges. It is acknowledged that participation in the workplace by some people with lived experience may require additional support for both the person and their employer and we will advocate for appropriate funding and support to help make this a reality. Where participation in work is not the most appropriate course for people, we will advocate for and promote full participation within education and training, and full inclusion in community life, helping to bring an end to stigma and discrimination in our workplaces and communities. We also recognise the importance of supporting employers to be able to create and support more mentally healthy workplaces, sustainable employment opportunities for people living with mental health difficulties and support for those in a family or caring role.

Together we will not only focus on prevention of mental illness and promotion of good mental wellbeing but also on early intervention and ensuring that those with lived experience are able to participate in skilled, meaningful work, where appropriate adjustments are made and individualised support provided to enable people to aspire to and achieve valued work. We are also committed to exploring and continuing to develop peer employment opportunities.

In advocating for and promoting initiatives addressing mental health issues in the work place, we commit to:

1. Involving a broad stakeholder group – comprising labour organisations, government, corporations, unions, the mental health community, providers, employees and employers and others in bringing about sustainable change.

2. Leading by example - as mental health organisations and departments, we need to be leaders and champions for this agenda and ensure our own workplaces are

psychologically healthy and safe. We should also model a workplace that includes people with lived experience and one that supports those who have a caring role.

3. Being inclusive – by including small and medium organisations in what we do and acknowledging that they are often the most impacted by economic, workplace and social pressures.

4. Supporting employers to create mentally healthy workplaces, adopt family and carer friendly employment practices, and improve opportunities for employing and sustaining the employment of people living with mental health difficulties and challenges1.

5. Supporting evaluation and the sharing of outcomes to facilitate employment and workplace initiatives.

As evidence of our commitment to work and mental health, over the next three years, we will move this issue forward in our programs and:

Action 8: Work collaboratively with employers to create and sustain a psychologically and physically healthy and safe work environment.

Action 9: Develop a parallel and linked agenda on access to work and maintenance in work for those with severe mental illness.

Action 10: Promote the collection of qualitative and quantitative data to demonstrate which programs, interventions and tools are effective and why.

Action 11: Share best practices and evidence on what works and what doesn't.

Action 12: Help develop clear expectations of the benefits of standards for psychological health and safety in the workplace through regulatory frameworks and guidance for employers.

Action 13: Share and advocate the use of the voluntary *Standard for Psychological Health and Safety in the Workplace* developed by the Mental Health Commission of Canada.

Exchanging Knowledge

We recognise the value of exchanging knowledge and learning with and from others who are working hard to improve the lives and opportunities of people living with mental health difficulties, their families and supporters. We are committed to finding creative and innovative ways of furthering the exchange of knowledge and the translation of knowledge into practice and for sharing this knowledge across systems, jurisdictions and international borders.

Action 14: We will continue to explore the exchange of knowledge and commit to developing further ways of sharing what we are learning together. We will aim to meet again in 2014 along with others to continue to pursue this.

International benchmarking

We also appreciate the value of finding ways to compare and contrast what we and others are doing and the importance of finding measures and indicators that help benchmark the differences we are making towards achieving a contributing life for people living with and recovering from mental health difficulties. We commit to sharing our work and practices in the development of indicators, data and benchmarking and to working to identify and

develop 'whole of life' benchmark indicators across jurisdictions and international borders by building on work under way to help creatively achieve our aspirations.

As a first step towards this, we are aware of the interest shown by a number of national and state governments in data and indicators. In Australia this is a current live issue that the National Mental Health Commission is supporting. Participants agreed to share their views and developing work on indicators; this will be of value to many participants, but will be of especial value to helping influence the work already underway in Australia.

In addition the parties have agreed to work together on two further priority areas:

Developing the peer workforce

We will work together to highlight the value and importance of the peer workforce in a range of settings. We will advocate for the expansion and development of the peer workforce.

Action 15: We will jointly facilitate and host a national peer work policy forum in Australia in 2014. This policy forum will be planned in consultation with peer worker representatives and will discuss the findings and recommendations of a study by Health Workforce Australia[4] into the peer workforce.

Review and evaluation

Wherever possible and appropriate, the parties will assist each other with major reviews, evaluations and strategic planning conducted by one or more party. This may take the form of facilitating community or stakeholder engagement and consultation or providing information.

The parties will also share their own performance evaluation frameworks with the other parties.

May 2014

[4] This report is expected to be released by Health Workforce Australia in 2014.