NSW GOVERNMENT | Health

# REVIEW OF THE MENTAL HEALTH COMMISSION OF NEW SOUTH WALES

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## — REVIEW OF THE MENTAL HEALTH COMMISSION OF NEW SOUTH WALES

**REVIEW OF THE MENTAL HEALTH COMMISSION OF NEW SOUTH WALES**

**TERMS OF REFERENCE**

## Background

The Mental Health Commission was established in July 2012 under the *Mental Health Commission Act* (the Act), for the purposes of improving the mental health system in NSW.

Following significant consultation undertaken by the Commission, *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024* sets the overarching direction for the provision of services and support to people in NSW that experience mental illness.

Five years following the establishment of the Commission, a review will be undertaken to consider *Living Well* and the significant work that has been undertaken by the Commission; and will identify opportunities to clarify, strengthen and focus the Commission's role and functions into the future.

This review will ensure that efforts continue to focus on the significant system reforms necessary to deliver an effective mental health system that is well placed to meet the demands of the future. This review meets the statutory requirements under section 20 of the Act.

## Purpose

The review will examine the extent to which the work of the Mental Health Commission has met the functions and principles given under the Act; and will make recommendations regarding the future role, functions, principles and priorities of the Commission.

The review will consider whether the policy objectives of the Act remain valid, and whether the terms of the Act remain appropriate for securing those objectives.

## Terms of the review

The review will consider:

Part A – Review of the work of the Commission

A1. The work of the Commission, taking into account the functions of the Commission as described in section 12 of the Act and the functions identified in the Ministerial Charter letter of 2016, and assess the extent these have been met. In particular, the Act outlines the following functions:

(i) prepare a draft strategic plan for the mental health system in New South Wales, monitor and report on the implementation of the strategic plan;
(ii) review, evaluate, report and advise on mental health services and other services and programs provided to people who have a mental illness;
(iii) promote and facilitate the sharing of knowledge about mental health issues;
(iv) undertake and commission research, innovation and policy development;
(v) advocate for and promote the prevention of mental illness and early intervention strategies for mental health, and the general health and well-being of people who have a mental illness and their families; and
(vi) educate the community about mental health issues.

A2. In exercising these functions, the extent to which the Commission has:

(i) focussed on systemic mental health issues; and
(ii) taken into account particular populations and issues, including co-morbid issues, the interaction between people who have a mental illness and the criminal justice system, and the needs of different sections of the community, including Aboriginal communities, culturally and linguistically diverse communities and regional and remote communities.

A3. The extent to which the principles governing the work of the Commission have been met, as described in section 11 of the Act, particularly:

(i) that people who have a mental illness have
    (a) access to the best possible care,
    (b) are treated with dignity and respect,
    (c) are supported to live fully in community life and lead meaningful lives; and

(ii) the extent to which the Commission has adopted a consultative, collaborative, whole of government and whole of community approach, enhancing integration and coordination across the mental health sector.

Part B – Future state recommendations

B1. To make recommendations regarding the future state of the Commission, including:

(i) role of the Commission;
(ii) functions of the Commission;
(iii) principles underpinning the Commission's work; and
(iv) priorities for the Commission.

Part C – Review of the Act

C1. Taking into consideration the work of the Commission, to report on:

i) whether the policy objectives of the Act, set out in section 3 of the Act, remain valid; and
ii) whether the terms of the Act remain appropriate for securing those objectives. Particular focus should be on
    a. whether the provisions of sections 11 and 12 appropriately set out the functions of the Commission and the principles guiding the work of the Commission,
    b. whether the reporting provisions of sections 13 and 14 remain appropriate,
    c. whether section 10 establishing the Mental Health Community Advisory Council in statute remains valid, with consideration to the role of any advisory group, and whether this is more appropriately an administrative function of the Commission.

**Governance**

The review will be led by Dr David Chaplow — former National Director of Mental Health and Chief Advisor, Ministry of Health, Wellington, New Zealand — reporting to the Minister for Mental Health, with Secretariat and management support from the Mental Health Branch.

**Methodology**

The review will:

- undertake a desktop review and analysis of the Commission's work;
- call for written submissions, and undertake thematic analysis of these;
- facilitate face to face consultations through one-to-one meetings and consultation workshops with key stakeholders; and
- provide a final report.

**Timeframe**

The Minister for Mental Health will table a report in Parliament on the outcomes of the review by 30 June 2018.

# APPENDIX 2
# REFERENCE GROUP TERMS OF REFERENCE

# Review of the Mental Health Commission of New South Wales

## Reference Group — Terms of Reference

**Background**

- The Minister for Mental Health, the Hon Tanya Davies has requested a review of the Mental Health Commission of New South Wales, consistent with section 20 of the *Mental Health Commission Act 2012*.
- The *Mental Health Commission Act* requires that as soon as possible after the period of 5 years from commencement (1 July 2012), the Minister undertake a review of:
    a) The work of the Commission taking into account the functions of the Commission and the principles governing the work of the Commission;
    b) A review of the Act to determine whether the policy objectives of the Act remain valid and whether the terms of the Act remain appropriate for securing those objectives.
- Dr David Chaplow has been appointed reviewer, responsible for leading the review and providing expert advice and input to the review process and approach.
- The Executive Director, Mental Health Branch is responsible for the administration and project management of the review, and ensuring that the review delivers on the Terms of Reference.
- The review will report to the Minister for Mental Health.
- The Act requires that the Minister table a report on the outcomes of the review within 12 months after the end of the relevant 5-year period (30 June 2018).

**Functions**

A Reference Group is being established to provide advice and input to the review. This will include advice on review process, approach, outcomes and deliverables.

**Responsibilities**

The Reference Group will:

- Provide input and advice on the review's overall approach, as articulated in the project plan, stakeholder engagement plan, and other plans that may be produced.
- Provide advice and input to the review outputs, particularly the draft review report.
- Members of the Reference Group will be invited to participate in stakeholder consultations as they are available.

**Members**

1. Dr Karin Lines, Executive Director, Mental Health Branch (Chair)
2. Dr David Chaplow, Reviewer
3. Ms Jenna Bateman, CEO, Mental Health Coordinating Council (substituted part way through the review by Carmel Tebbutt)
4. Ms Irene Gallagher, CEO, Being
5. Mr Jonathan Harms, CEO, Mental Health Carers NSW
6. Mr Tom Brideson, State-wide Coordinator, NSW Aboriginal Mental Health Workforce Program
7. Dr Claire Jones, Mental Health Director, SWS LHD (metro representative)
8. Dr Richard Buss, Mental Health Director, NNSW LHD (rural representative)
9. Ms Robyn Bale, A/Executive Director, Learning & Wellbeing, NSW Department of Education
10. Mr Christopher Leach, Deputy Secretary, Disability Operations, NSW Department of Family and Community Services
11. Mr Tim Hampton, Executive Director Health, Intergovernmental and Education, NSW Department of Premier and Cabinet
12. Mr Paul McKnight, Executive Director, Justice Strategy and Policy, NSW Department of Justice
13. Ms Catherine Lourey, Commissioner, Mental Health Commission (Observer)

**Secretariat**

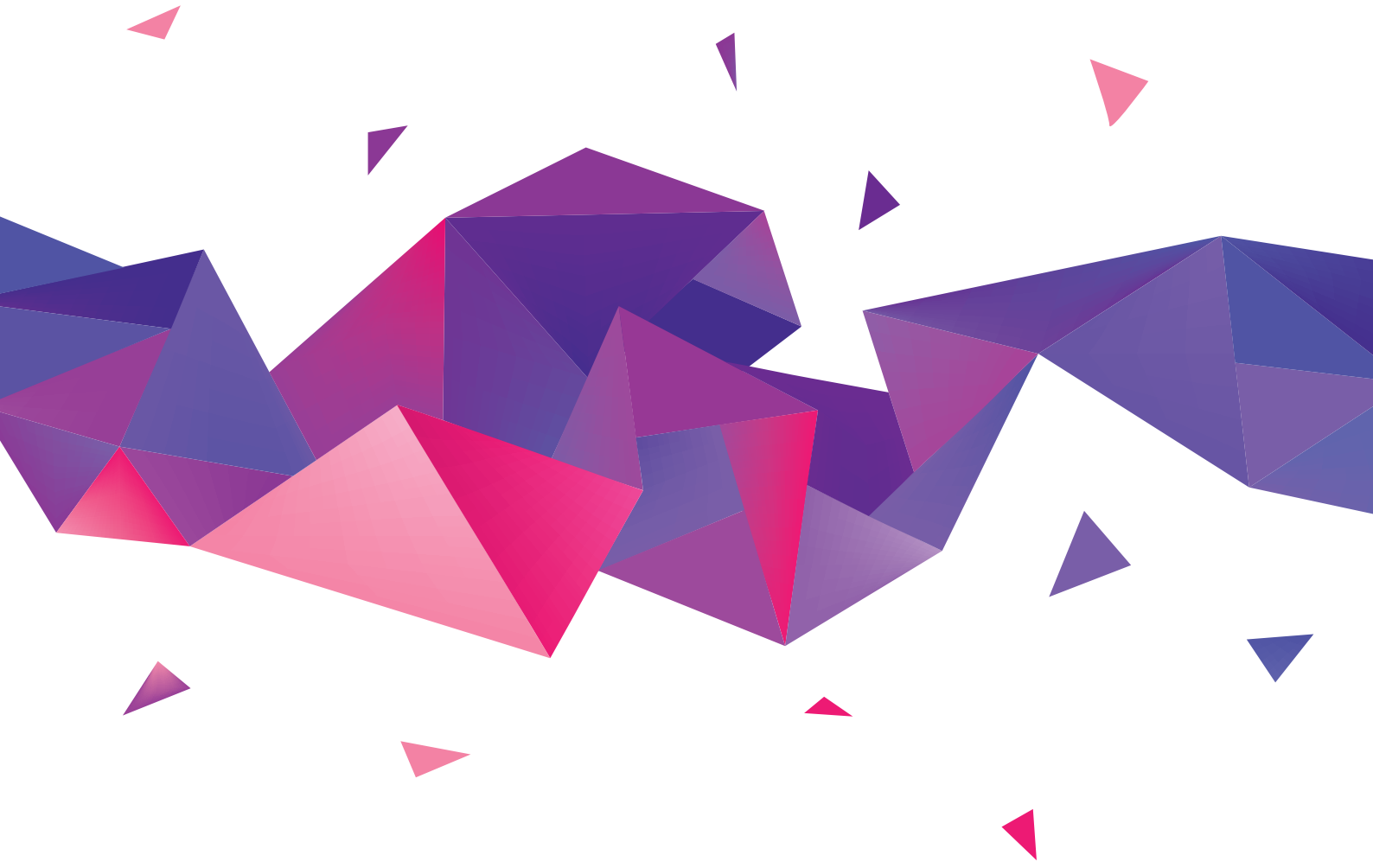
1. Claire McKendrick, Project Lead, Mental Health Branch

Proxys: Members are encouraged to nominate a proxy should they be unable to attend a scheduled meeting in person (or by teleconference).

**Schedule of meetings**

The Reference Group will meet as required throughout the review.

# APPENDIX 3
# MENTAL HEALTH COMMISSION SUBMISSION TO THE REVIEW



# Statutory Review: The work of the Commission (A1 –A3)

## Introduction

This document provides an overview of the Commission's work from establishment to 31 July 2017. It is intended as a guide for deeper engagement with the Commission's work program and activities. It is not a detailed or complete description of everything the Commission has done. Importantly, this paper does not go into the detail of how the Commission has worked, the nature of its engagement or the full impact of its work over the past five years.

The Commission takes a holistic view of its work. This means there is significant interaction between projects and one project often addresses several different statutory functions. The following summary gives a general overview of the Commission's work over the past five years, grouped loosely by theme. Much more information can be found on the Commission's website and through our annual reports.

The Commission has no role in the provision of mental health services. Rather, the Commission is an intermediary agency. As an intermediary organisation, the Commission's impact is based on how it influences other government agencies, the community managed sector and the community more generally to make positive changes that improve the mental health system and the mental health and wellbeing of the people of NSW. One example of this is through the Government's adoption of *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024*, and its progressive implementation of the 10-year reform agenda. The *Living Well* reforms are really about creating consensus and momentum for change, and in recent years there has been an upsurge in new work undertaken by others, with reference to *Living Well* but without the direct involvement of the Commission. This is a powerful indicator of the success of the reform principles, which clearly resonate in the community, and of their sustainability. However, as an intermediary organisation, the Commission works in many additional ways to spark the ideas, develop the evidence, seed the projects and foster the connections and relationships that make change possible.

The Commission has a broad remit. Under our legislation we are required to monitor, review and improve the mental health system and the mental health and wellbeing of the people of NSW. An important focus in carrying out this work is on the social determinants of health. That is, looking at the social and economic factors that impact on individual health outcomes. We know that disadvantaged populations experience poor health outcomes at higher rates than the rest of the population, accordingly much of our work to improve the mental health and wellbeing of the people of NSW is directed to address the impacts arising from these health inequities.

For example, through 2015 - 2017 we have undertaken a broad program of work directed to developing a better understanding of the interaction between people with mental illness and the criminal justice system (as required under s 12 (2)(c) of the Act). These projects include a range of activities from community consultation

through to academic research and all are directed to improving our understanding and response to people with mental illness who come into contact with the criminal justice system.

The table in Appendix One sets out the activities of the Commission over the past five years categorised by function and the principles reflected in the work.

In July 2012, the Commission was established as an entirely new organisation. It took a substantial effort just to become fully operational. All aspects of the organisation needed to be developed from accommodation to staffing structures to accounting and risk management systems. There is more detail on this at Appendix Two.

## Themes

1. Preparing *Living Well: A Strategic Plan for Mental Health in NSW 2014 - 2024*
2. Monitoring *Living Well: A Strategic Plan for Mental Health in NSW 2014 - 2024*
3. The voice of lived experience
4. The mental health system
5. Suicide prevention
6. Justice
7. Law
8. Broader than the 'mental health system'
9. Resilience and wellbeing/ community
10. Mental health in the workplace
11. Children and young people
12. Disability inclusion
13. Research
14. Beyond NSW

## Preparing Living Well: A strategic plan for mental health in NSW 2014 - 2024

### Goal

To prepare a strategic plan for the mental health system in NSW that took into account the range of significant issues that impact on individuals with mental health problems, their families and carers. This includes health, housing, education, employment, the criminal justice system and other key systemic issues. The Plan was directly informed by the preferences, wishes, needs and aspirations of people with a lived experience of mental illness and their carers and families.

### What the Commission has done

- In May 2014, the Commission submitted the draft Strategic Plan to the Minister for Mental Health. In December 2014, the NSW Premier released the Plan, committing the Government to all its 141 actions as well as its core direction of redesigning the mental health system to better respond to the needs and wishes of people who experience mental illness, and their families and carers.
- Alongside the Strategic Plan, we released *Living Well: Putting people at the centre of mental health reform in NSW: A Report.* The report, which was tabled in Parliament on 14 October 2014, tells the story of mental health and wellbeing in NSW from the perspective of people who live here.
- In developing the Report and Plan the Commission consulted more than 800 consumers and carers, to ensure their experiences and needs were at the heart of all changes to the NSW mental health system.

- The Commission engaged with government and community organisations working across the full spectrum of mental health supports and hosted workshops with key agencies to develop the themes which underpin the Strategic Plan
- More than 2100 people participated in our stakeholder consultation forums and community meetings all over NSW (including Albury, Wagga Wagga, Narrandera, Leeton, Griffith, Dareton, Broken Hill, Wilcannia, Walgett, Lightening Ridge, Moree, Dubbo, Wellington, Mudgee, Orange, Katoomba, Penrith, Blacktown, Sydney, Wollongong, Nowra, Queanbeyan, Goulburn, Gosford, Newcastle, Tamworth, Inverell, Armidale, Kempsey, Coffs Harbour, Lismore, Ballina). Out of these community consultations the Commission created papers that supported the development process for *Living Well*. These included: *Yarning honestly about Aboriginal mental health in NSW*; *Living Well in our Community* (consumer perspectives on mental health reform); and, *Listening to the people of regional NSW*.
- We commissioned specialised research projects across a range of topics to inform the development of the Strategic Plan as well as receiving written submissions and participating in online consultations.

### How it's improving mental health and wellbeing and the mental health system

*Living Well* sets a clear direction for reform of the mental health system and the mental health and wellbeing of the people of NSW. The reforms are informed directly by the voice of people with a lived experience of mental illness and their families and carers. It has large scale buy in across government and the community.

## Monitoring *Living Well: A Strategic Plan for Mental Health in NSW 2014 – 2024*

### Goal

To monitor the implementation of the Plan and to support its adoption across the whole of government and the community.

### What the Commission has done

- In January 2016 the Commission provided the Mental Health Minister with a reform progress report, *One Year On*. The Report described the status of the government's work towards its commitments under the Strategic Plan as at December 2015. We drew from government agencies' responses to an information request; our own observations through our community visits and ongoing engagement with agencies, the community-managed sector, peak representative groups and the community; published data; and an online

survey which attracted 744 organisational and individual respondents. A further reform progress report is currently under development.

- Following the release of the Plan, the Commission offered grants of up to $30,000 to every LHD to allow them to initiate a reform-related project. These grants funded diverse activities including community consultations, training programs and the engagement of consultants from jurisdictions including New Zealand which have previously adopted similar person-centred reforms. The Commission has undertaken a regular program of extended visits to communities across NSW to gain an in-depth understanding of those communities' particular issues and to learn about opportunities and barriers in progress towards the *Living Well* reforms. As part of those visits we also investigate service innovations that might have potential to be replicated elsewhere in NSW. We have visited Port Stephens, Clarence Valley, Orange, Far West NSW, Southern NSW, Mid North Coast, Murrumbidgee, Western Sydney, Nepean and the Blue Mountains, Central Coast and South West Sydney.
- As part of the Commission's annual community visits across NSW, we have met with Aboriginal communities to learn about their emotional and social wellbeing and to gather and share examples of Aboriginal leadership and healing. For example, in 2015 we visited the Maari Ma Health Aboriginal Corporation in far west NSW to learn about their healing program and its impact. Our findings are captured in a visit report and online video. We have also profiled the Guunumba Sit Down Circles (Yarning Circles) that run in Coffs Harbour and Durri Aboriginal Medical Service in Kempsey. More recently we have worked with the Tharawal Aboriginal Corporation at Campbelltown and Weave Youth and Community Services at Waterloo to document their approaches to supporting Aboriginal clients through video profiles.
- To assist with monitoring the progress of mental health reform, the Commission has conducted two Community Surveys to gather the views of consumers, families and carers, and people working in the sector. The 2015 Ready for Change Survey collected responses from 744 individuals on their understanding of Living Well, to assess the success of dissemination of the Plan and also community confidence in its implementation. The results of this survey are presented in *One Year On*. The Evidence of Change Survey was conducted in September 2016 and collected feedback on the community's perceptions of mental health reform in NSW and their experiences of implementation so far. The results of this survey, which attracted 1510 respondents, are available on the Commission's website.

**How it's improving mental health and wellbeing and the mental health system**

The *Living Well* reforms are about creating consensus and momentum for change. Through its monitoring and reporting role the Commission provides transparency and accountability to the people of NSW regarding progress on implementation, and also

contributes to ensuring a continued focus on implementation across government and the community.

## The Voice of Lived Experience

### Goal

People with lived experience of mental illness, and their families and carers, are at the centre of all of the work of the Commission, and their knowledge and experience is invaluable in guiding our way forward. We make sure people's voices, concerns and ideas are heard, not only in the public domain but in every arena where decisions are being made. A growing body of evidence shows that services designed in collaboration with those who use them are more effective. This is a model we actively promote through our work.

### What the Commission has done

- Consultation with consumers, their families and carers, is as much about how the Commission works, as it is about what we do. The Commission consults regularly with consumers at all stages of our work. This is highlighted in discussion of the specific projects we have conducted in relation to other themes.
- The Commission also asks consumers and carers about their experiences of the NSW mental health system and whether they are seeing difference following the *Living Well* reforms. More than 58% of respondents to our 2016 Evidence of change survey identified as consumers or carers, and their input is central to our analysis and reporting.
- The Commission believes people with experience of mental health issues have a unique ability to help others who are unwell, and are vital in NSW's mental health workforce. The Commission has supported the growth of peer worker numbers via a number of initiatives including our Peer Work Hub. Launched in 2016, this website provides evidence and advice to employers on how they can introduce or grow a peer workforce, overcoming misconceptions and barriers and providing practical resources such as template role descriptions. The Hub has had more than 3500 users since its launch. The growing support for peer work was demonstrated when the Ministry of Health appointed its first ever Peer Workforce Coordinator in 2016.
- The Commission established a Consumer Lived Experience Steering Group in 2016 and asked its members to develop a priority project that they thought would make the greatest positive impact. Supported by the Commission, participants consulted with 150 fellow consumers around NSW and the resulting project - a guide for government and community agencies on how to foster meaningful consumer and carer participation, influence and leadership - is in development.

- In order to highlight the ways that mental health carers and families can shape reform, the Commission established a Carer Lived Experience Steering Group in 2017. Supported by the Commission, the group is exploring the topic of carer participation, influence and leadership in order to inform the abovementioned guide for government and community agencies on how to foster meaningful consumer and carer participation, influence and leadership.
- In June 2017 the Commission hosted families and carers of those living with a mental illness at a one-day workshop in Sydney, called "*A Caring Collective: empowering mental health carers and families'.* The event focused on ways carers and families can get their voice heard, whether in individual care decisions or shaping the way organisations respond to carer needs. We provided travel assistance so families outside of Sydney could attend.
- The Commission shines the light on personal experiences of mental illness through the stories we include in our videos, publications, website and other communications. We work to ensure that clinicians, government agencies, organisations, and networks that treat and care for people with mental health issues hear those written and filmed stories, so that the people behind them are always front of mind. We have captured and promoted more than 40 personal stories so far.
- Through our partnership with Being and Mental Health Carers NSW the Commission ensures there is a direct conduit for consumers and carers to participate in the policy and program development process.

### How it's improving mental health and wellbeing and the mental health system

A mental health system in which consumer and carer voices are sought, listened to and respected will be more accessible, more accountable and more effective at helping people along their recovery journey.

## The Mental Health System

### The goal

To monitor, review and improve the mental health system.

### What the Commission has done

- During 2016/17 the Commission undertook a review of the transparency and accountability of mental health budgets in health services, with the support of two expert consultants (Dr Tim Smyth and Mr Rob Mathie) The review sampled the government arrangements for four local health districts (LHD), Hunter New England, North Sydney, Western Sydney and Western NSW and was further informed by a series of face to face meetings with the Ministry of Health, the relevant LHDs and other key stakeholders, such as the Royal

Australian and New Zealand College of Psychiatry. The report arising from the review has been delivered to the Minister for tabling.

- Following a request from the Minister for Mental Health in 2013, the Commission conducted a functional review of the Institute of Psychiatry (IoP). The review recommended that the IoP be aligned with the mainstream mental health workforce to maximise opportunities for shared education and training and integrated governance and planning. These recommendations were accepted and the Commission chaired the committee overseeing the staged transition process for the administrative integration of IoP with the Health Education and Training Institute. The Commission's role has now ended with HETI gaining accreditation as a training provider in place of the IoP and the IoP legislation has now been repealed.
- The Commission funded the University of Sydney in 2014/15 to develop a Mental Health Atlas of Far West NSW, which for the first time offered policy-makers and planners a consistent way to classify and geo-locate the range of mental health services available in the region across health, social care, education, employment and housing. The pioneering concept has been adopted across NSW and Australia, including in the Sydney metropolitan areas which will be fully mapped in 2017. Regional atlases are under development in the ACT, Victoria and Queensland, while the Western Australia Ministry of Health is funding the mapping of all services in Western Australia.
- In 2014 – 15 the Commission contracted the University of NSW (UNSW) to develop a network of hospitals that conduct electroconvulsive therapy (ECT) to contribute to a world-first clinical database with potential to identify the safest and most effective approaches to ECT and to train clinicians in their use. This has subsequently developed into the Clinical Alliance and Research in ECT (CARE) network, with 32 participating Australian hospitals, including 17 in NSW, as well as hospitals in Singapore, Spain and Belgium. 75 NSW clinicians have been trained in cognitive testing for ECT consumers.
- The Commission worked with the NSW Government, the Australian Bureau of Statistics, universities and more to build a suite of interactive data presentations and snapshots that make NSW mental health-related data more accessible to everyone. Topics that users can explore include: access to mental health services; patterns of treatment; use of mental health services and medications; disadvantage and stress; psychological distress and health; and suicide. The Commission will add interactive presentations and snapshots on other topics over time.

**How it's improving mental health and wellbeing and the mental health system**

By providing clear and transparent advice and information on the mental health system, reviewing key aspects of the system and presenting new analyses we help build the evidence base and inform directions for mental health reform.

## Suicide prevention

### The Goal

Suicide and attempted suicide are the most devastating consequences of mental distress. In NSW in 2015, 815 people took their own lives. Many more consider, plan or attempt suicide. There is a wealth of evidence that shows suicide and the suffering it represents can be prevented through strategies aimed at individuals and entire communities. One of the Commission's priorities has been to ensure this evidence is put into action.

### What the Commission has done

- The Commission engaged the Centre of Research Excellence in Suicide Prevention (CRESP) to come up with a detailed plan for how multiple, proven suicide prevention strategies could be rolled out in NSW in a co-ordinated and effective way. The resulting proposed Suicide Prevention Framework for NSW was the first study in Australia to show how this 'systems approach' to suicide prevention could be implemented, how much it would cost and the potential benefits. Following the launch of the framework, the Ramsay Foundation provided Black Dog Institute $14.7m in funding to run a world-first suicide prevention trial in NSW, called LifeSpan. LifeSpan is implementing nine different evidence-based suicide prevention strategies in four towns in NSW over six years.
- There are a lot of organisations and individuals working on suicide prevention in NSW. The Commission established the Suicide Prevention Advisory Group to get leaders in this area – including people who've been personally affected by suicide - all together in one room every six months to share information and increase coordination. This Group is co-chaired by the Ministry of Health.
- To support individuals, families and professionals to talk about suicide in a safe and productive way, the Commission partnered with the Hunter Institute of Mental Health and produced an online resource called Conversations Matter. Since its beginnings in 2013, the resource has grown to include materials tailored for professionals working with Aboriginal communities and culturally and linguistically diverse communities.
- To support towns to turn conversations and concern about suicide into effective local action, the Commission partnered with the Hunter Research Institute and produced an online resource called Communities Matter. The resource is a plain language guide to combating suicide and stigma via community action.
- The Commission provided funding to the Black Dog Institute to enhance and extend iBobbly, a smartphone app designed to reduce suicidal thinking among Aboriginal people aged 16-35. Our funding meant Black Dog was able to adapt the app for national use, so Aboriginal communities beyond the Kimberley region could use it; made it more user friendly, such as via a clearer navigational structure and more videos; and made it accessible on Apple devices, in addition to its original Android design.

- To help raise awareness of mental health and in particular suicide prevention in multicultural communities, the Commission has participated in Together for Hope a candlelight walk through Auburn held each year. The Commission has also produced a video of this event which highlights the experience of mental illness within NSW's culturally and linguistically diverse (CALD) communities, as well as local leaders' ideas to increase help-seeking among community members.

**How it's improving mental health and wellbeing and the mental health system**
The Commission's efforts over the past five years have supported suicide prevention activity in NSW to be more effectively coordinated, monitored and planned. The Lifespan trial has the potential to reduce suicide deaths by 20% and attempts by 30% in the four NSW sites in which it is being implemented. The Suicide Prevention Advisory Group ensures more co-ordination and less duplication among those leading suicide prevention work in NSW. And individuals, families and frontline workers have materials to help them talk and act to prevent suicide, including culturally appropriate tools. This is especially vital, as suicide prevention is not in the hands of mental health workers alone: it is everyone's responsibility.

## Justice

### The goal

To improve our understanding and response to people with mental illness who come into contact with the criminal justice system to support all to live well and safely in community and enable individuals to lead meaningful and contributing lives.

### What the Commission has done

- The Commission liaised closely with a broad range of stakeholders to review the issues experienced by people who live with mental illness when they come into contact with the criminal justice system. A report has been developed, *Towards a Just System*, which suggests pathways forward to address the needs of this cohort. The report was guided by an expert reference group and developed in consultation with the relevant government agencies. It was launched at a forum on 27 July 2017 at Parliament House with senior executives from across government.
- The Commission partnered with the Kirby Institute to undertake a data linkage project, bringing together records from Health, Bureau of Crime Statistics and Research and Corrective Services to gain a better understanding of the impact of psychosis on offending behaviour.
- To improve our understanding of the forensic patient journey, the Commission partnered with A/Prof Kimberlie Dean (UNSW) to develop an electronic database that contains detailed and anonymised demographic, clinical and legal information about forensic patients. The database contains information on over 250 variables on almost 500 forensic patients from records kept over the past 25 years. The next phase of this work will see the database linked to

longitudinal administrative health and criminal justice datasets. Ultimately the forensic patient database aims to provide the information needed to enable evidence-based developments in the services and interventions offered to forensic patients in NSW, improving the health of forensic patients and enhancing community safety.

- The Commission engaged Dr Leanne Craze to document the evidence base for implementing recovery oriented, trauma informed approaches in justice settings across NSW. Dr Craze undertook a literature review and a targeted survey of people with lived experience of mental illness and the criminal justice system and with professionals who work in the system. We have developed the results of Dr Craze's research into a discussion paper, which was circulated among key stakeholders in late July 2017, with a view to developing fit for purpose guidelines for NSW justice settings.
- The Commission participated in the senior officers group in Government's consideration of the NSW Law Reform Commission Reports, *People with Cognitive and Mental Health Impairments in the Criminal Justice System – Diversion* and *Criminal Responsibility and Consequences*, and have continued to engage with Justice around consideration of reforms at both the state and national level.

### How it's improving mental health and wellbeing and the mental health system

A significant body of this work is still underway. However, already achievements have been made in bringing together the major stakeholders in this space to have the discussion about a way forward.

## Law

### The goal

The Commission seeks to influence good practice in policy design and implementation. An important aspect of policy development is the legislative framework within which that process occurs.

### What the Commission has done

- Along with Legal Aid, the Commission co-chairs the Health Justice Partnership Community of Practice. This is a cross-sector working group that brings together experts in the health, legal and community service sectors with an interest in the health justice partnership model. The purpose of the group is to explore opportunities for collaboration to improve health, wellbeing and legal outcomes for disadvantaged communities. To support this ongoing collaboration we developed a position paper, which articulates what a health justice partnership is with particular reference to the NSW context and in early

2017 the Commission co-hosted, with Legal Aid NSW, a forum on consumer participation in health justice partnerships.

- In 2014, the *Mental Health Act 2007 (NSW)* was reviewed. The Commission participated in the review process through a range of consultation mechanisms. The Commissioner was a member of the Ministry of Health's Expert Reference Group and attended six of eight community consultation forums held across NSW as a member of the Mental Health Act Review Panel. During Phase Two of the review the Commission had detailed meetings with the Ministry to discuss issues arising in the review as well as attending meetings organised by the Ministry to consult with stakeholders. The Commission also provided written submissions. Following the subsequent changes to the Act we worked closely with partners to ensure that the changes were well understood across the whole community. The Commission was a member of the Institute of Psychiatry's Mental Health Legislation Training Framework Expert Reference Group, to support the IoP in the delivery of education and training enabling mental health practitioners to apply relevant mental health legislation to their professional practice. The Commission also funded the Mental Health Coordinating Council to update the Mental Health Rights Manual.
- The Commission provided a submission to the Commonwealth Community Affairs References Committee on the issue of indefinite detention of people with cognitive and psychiatric impairment in Australia. As part of this submission we raised a number of possible areas for improvement, relevant to the Committee's terms of reference.
- Throughout 2016 and 2017 the NSW Law Reform Commission has been reviewing the *Guardianship Act 1987 (NSW).* We have provided submissions on the six consultation papers released by the Law Reform Commission, as well as providing a preliminary submission and participating in a face-to-face consultation. The submissions advocate for the introduction of a supported decision making model and a series of changes aimed at promoting the dignity and rights of people with a disability, including people who experience mental illness, in line with Australia's obligations under the United Nations Convention on the Rights of Persons with Disabilities.
- The Commission participated in the review of the *Coroners Act 2009 (NSW)* through a series of face to face consultations as well as providing written submissions. As part of its submission, the Commission advocated for increased emphasis on the coroner's preventative role and provisions to support this. The Commission also argued for clarification of definitions as they relate to people with mental illness and reviewing the deaths of people with mental illness.
- The proposed Social Services Legislation Amendment Bill 2015 contained provisions which would have had a significantly detrimental impact on the lives of people found not guilty by reason of mental illness or unfit to stand trial. The Commission wrote to the Senate Standing Committee on Community Affairs inquiry into the Bill raising these concerns.

### How it's improving mental health and wellbeing and the mental health system

Many of the changes the Commission has recommended through its submissions on the above reviews have been adopted in the revised legislation, or quoted as possible models in subsequent consultations. While the content of the Commission's recommendations varies depending on the topic, some core values are consistent across the submissions. These values can be summarised as the principles governing the Commission's work, as set out in s 11 of the Act.

## Broader than the 'mental health system'

### The goal

We know there is no health without mental health and this is true throughout life. Also people with severe and persistent mental illness have significantly poorer physical health outcomes than the rest of the population. But this connection is not inevitable, the Commission supports policy and practice development to improve the physical health of mental health of everyone.

### What the Commission has done

- The Commission worked with mental health and ageing organisations, as well as older people with lived experience, to develop *Living Well in Later Life: The Case for Change*. This resource will be used to support discussion and collaboration among government, the community managed sector and private stakeholders about reforms in this area.
- The Commission gathered more than 160 submissions from consumers and carers about their experiences of medications for mental illness and published these in a paper and series of short films. Personal experiences of medication use carry the same weight in these materials as those of health professionals and researchers, and highlight both good practice and things that needed to change to promote safety and focus on recovery.
- Based on consumer input, we also created a postcard-size discussion guide about medication that people can take to their doctor or pharmacist and that has been distributed to more than 2000 pharmacies and neighbourhood centres across NSW. Through this project the consumer and carer voice is heard in settings like the Health Education and Training Institute (HETI), which now uses the medication project resources when training NSW Health staff
- The Commission established a Pharmacotherapy in Mental Health Advisory Group to advise the Commission on existing research and evidence in relation to pharmacotherapy and mental health. The Group brings together professionals, consumers and cares and identifies where the Commission can meaningfully contribute to the promotion of good practice in this area. The Group also guided the development of the above *Medications and Mental Illness Report* described above.

- The research from the above process informed the Commission's submissions to the Commonwealth Department of Health on their Clozapine Issues Paper and to provide a response to the National Safety and Quality Health Standards Review: Standard MS: Medication Safety.
- The Commission has partnered with the Centre for Disability Research and Policy at the University of Sydney in a project led by A/ Prof Jennifer Smith-Merry to understand the utility of coronial data for understanding mental health related deaths. The work is ongoing, and when complete will help us to understand a broad range of circumstances in relation to mental health related deaths.
- To support the development of good practice in relation to physical health and mental wellbeing, the Commission developed the *Physical Health and Mental Wellbeing Evidence Guide*. The Guide discusses the evidence for comprehensive lifestyle interventions to help improve the physical health of consumers living with severe mental illness. It provides evidence from proven strategies to improve access to physical health services, as well as health promotion, prevention and early intervention for people with coexisting mental and physical health issues.
- Following our advocacy, the National Mental Health Commission took up the important issue of improving physical health outcomes for people who experience mental illness and brought together all the jurisdictions to develop the Equally Well National Consensus Statement, released by the Commonwealth Health Minister on 25 July 2017. Throughout 2015 and 2016, we sat on an expert advisory committee which drove the development of that consensus statement.
- Following the advocacy of the Commission, in September 2013, the NSW Government adopted the Health Active Lives (HeAL) program principles. HeAL is directed to improving the physical health of young people who experience psychosis. It aims to reverse the trend of people with severe and persistent mental illness dying early by tackling risks for future physical illness pro-actively and much earlier.

**How it's improving mental health and wellbeing and the mental health system**

There is now growing recognition of the role all health providers play in ensuring the mental health and wellbeing of people. Also there is a growing national consensus on the importance of improving physical health outcomes for people who experience severe and persistent mental illness with the Commission providing resources and contributing to the evidence base to support services in implementing changes to improve outcomes. .

## Resilience and wellbeing/ community

### The goal

To improve the mental health and wellbeing of the people of NSW.

### What the Commission has done

- The Commission initiated the NSW Wellbeing Collaborative, made up of representatives from across government and the community, as a platform to share knowledge and promote innovative and successful wellbeing activities.
- Working in partnership with the Centre for Rural and Remote Mental Health the Commission is developing a model for Community Wellbeing Collaboratives.
- The Commission has promoted the use of Mental Wellbeing Impact Assessments (MWIA) among government agencies to assess the impact of polices, programs and services on the wellbeing of individuals, stakeholders and communities. This has included hosting workshops and training sessions in the MWIA methodology, and training staff at the Department of Education, Family and Community Services, iCare, ACON and the Centre for Rural and Remote Mental Health to facilitate the MWIA process.
- The Commission is continuing work to develop a suite of resources to support and promote the adoption of a wellbeing focus across government and the community. As part of this the Commission hosted an International Wellbeing Indicators Workshop, bringing together international experts in wellbeing to identify tools available to measure wellbeing. In developing these tools the Commission has worked closely with social designers from the University of Technology Sydney (UTS) and the Centre for Social Impact at UNSW.
- The Commission engaged Aboriginal-led consultancy Cox Inall Ridgeway to undertake a preliminary mapping of policies across Government that relate to the mental health and wellbeing of Aboriginal people at the end of 2016/17. This provides a context for further engagement with agencies and the development of further work in relation to Aboriginal Social and Emotional Wellbeing.
- The Commission adapted and brought to Australia a US-developed model of promoting mental wellbeing, called Check-Up from the Neck-Up. The model involves offering free, evidence-based wellbeing assessments to community members passing by busy locales, to increase awareness of wellbeing and its importance. Over 2016-17 the Commission staged three ‘Check Up’ events, reaching people in Sydney’s CBD and multicultural suburbs as well as regional and rural visitors to Sydney’s Royal Easter Show. National media coverage and promotional materials spread the initiative’s wellbeing message well beyond the 300-plus community members who had an individual ‘check-up’. Commission staff were supported at the events by clinicians and peer workers from Local Health Districts, specialist teams, including the Transcultural Mental Health Centre, peer workers and non-government

organisations, putting into practice *Living Well's* focus on co-ordinated, person-centred care.

### How it's improving mental health and wellbeing and the mental health system

Together this work provides opportunities to emphasise the benefits of good mental health and build the individual and community resilience that underpins it. This is invaluable in contributing to reducing stigma and discrimination, providing opportunities for people to seek assistance and for agencies to better engage with wellbeing across communities to assist in those goals.

## Mental health in the workplace

### The Goal

Most adults in NSW spend a lot of their time at work, travelling to work or thinking about work. So workplaces are a key setting to promote our all-of-society approach to mental health. The Commission has been working to ensure that workplaces can identify if someone is struggling and promote their recovery, accepting the challenge of not just keeping employees physically safe, but keeping them mentally healthy too.

### What the Commission has done

- The Commission brought together NSW's first responder agencies - NSW Police, Fire & Rescue NSW, NSW Ambulance, NSW State Emergency Service and NSW Rural Fire Service - with research experts and devised a shared mental health and wellbeing strategy for their staff and volunteers, who are regularly exposed to different types of trauma. This 2016 initiative was Australia's first ever cross-agency mental health strategy for first responders, and the Commission was central to its development, publication and launch. The Commission also teamed up with iCare to produce a series of videos that first responder agencies use in their workplaces to help staff and volunteers understand why and how they can look after their mental health. The videos have been used in NSW Police training sessions and multiple agencies' mental health education days and had more than 6000 views by June 2017.
- In 2016, the Commission held a free community event, called Living Well @ Work, that provided advice to employees and employers about managing mental illness in the workplace. We filmed the evening and the advice is now freely available via a series of videos on YouTube. The videos cover common concerns such as whether to tell your boss you have a mental illness and how to respond when an employee explains they are mentally unwell. The Commission has promoted the videos through human resources publications to ensure they get out to all workplaces in NSW.

- The Commission has joined with partners including iCare (through a Memorandum of Understanding), Safework NSW, WayAhead and beyondblue to collaboratively provide ongoing advice and advocacy on this issue. When we work together, the message comes through louder and stronger.

### How it's improving mental health and wellbeing and the mental health system

Moving the focus away from reacting to employees' mental illness and towards proactively fostering employees' wellbeing will mean healthier, safer workplaces in NSW. We need leaders in this effort, and NSW's first responder agencies have set a wonderful example for other industries about how a sector can work together to create a mentally healthier environment.

## Children and young people

### The goal

Children and young people span an age group from birth through to 25 years old. The range of issues experienced by this cohort is hugely varied. Despite the significant variation in experiences across the cohort, what is shared in common is the opportunity for mental health and wellbeing initiatives to make a lasting, lifelong difference.

### What the Commission has done

- The Commission partnered with the Young and Well Cooperative Research Centre and the Brain and Mind Centre to trial an innovative online system of integrated apps and e-tools, designed to help young people improve their mental health and wellbeing. A key feature of the system was the interoperability of the integrated services, which guide the young person through the ecosystem based on their specific need. The trial engaged young people (aged 16 to 25) in three NSW communities (Western Sydney, Central Coast and Far West) in a participatory design and evaluation approach.
- Directly informing the Commission's work with the Young and Well Cooperative Research Centre, we also partnered with Reachout.com to support a pilot of an online tool *Pathways to Mental Health Care in Western NSW* in the Western NSW local health district. This demonstrated the effectiveness and acceptability of stepped care approach to improve mental health and increase service access and use by vulnerable young people.
- The Commission partnered with the Butterfly Foundation to engage with more than 100 Australians who had experienced an eating disorder about what helped and hindered their recovery, and had their advice turned into a resource for health professionals. The resource, called *Insights in Recovery: A consumer-informed guide for health practitioners working with people with eating disorders*, was released in November 2016 and has been downloaded

more than 1500 times. It identifies for health professionals eight key things they can do to support people to recover, such as discuss with clients what recovery entails and help them to feel safe. A direct mail campaign to GPs is underway.

- The Commission partnered with the then NSW Commission for Children and Young People to develop a report *Support in Tough Times: Encouraging young people to seek help for their friends.* The report identifies the important role of friends in seeking adult help for young people with mental health problems. It also demonstrated for the first time that schools play an important role in overcoming barriers to help-seeking among young people. 3,241 young people participated in the research and an advisory group of young people provided feedback and advice throughout the research and report writing process.
- The impacts of childhood trauma have long lasting and pervasive effects on survivors. The Commission had actively engaged with the Royal Commission into Institutional Responses to Child Sexual Abuse. The Commission's advocacy in this space has included giving oral evidence before a public hearing – Case Study 57, inquiring into the nature, cause and impact of child sexual abuse in institutional contexts in Australia. The Commission took the lead in developing a consensus statement on behalf of all mental health commissions in Australia on the essential elements that will need to underpin the recommendations of the Royal Commission in respect of the mental health impacts of institutional child sexual abuse. The Commission also invited Commissioner Helen Milroy to present to over 300 delegates from around the world at the International Initiative for Mental Health Leadership Conference in early 2017.
- Blue Knot Foundation was engaged to conduct a literature review about the safety of media and other public conversations concerning child sexual abuse. This work delivered at the end of 2016/17 makes recommendations about further potential projects, including the development of media guidelines.
- The Commission hosted a public forum for over 150 people to learn how to assist young people to stay safe and well as they use digital technologies. The forum, called *Growing Up Digital*, was chaired by digital journalist and founder of the Mamamia Women's Network, Mia Freedman, and included panellists Jonathan Nicholas, CEO of Reachout.com, and Samantha Yorke, Director of Public Policy at Google.
- Open Dialogue is an innovative, network-based approach to assist people, usually young people, who experience psychotic crises and conditions. In 2015, the Commission hosted Dr Christopher Gordon and Brenda Miele Soares from the United States to present a forum about their experiences implementing the program in Massachusetts. The Commission has also partnered with Prof Niels Buus, the St Vincent's Chair of Mental Health Nursing at Sydney University, to bring together interested academics, carers, clinicians and peers to discuss how the Open Dialogue approach might be implemented at a significant scale in NSW.

- The Commission contributes to the development of good practice in relation to provision of care and support to children and young people by providing policy advice across a range of participation mechanisms. The Commission has provided written submissions on the NSW Youth Health Policy and Family and Community Services Targeted Early Intervention Program Reform. In 2015, the Commission showcased a unique model of care for vulnerable children, *Wraparound Milwaukee*, when it invited the model's founder and former administrator to speak with NSW organisations charged with caring for vulnerable children.
- The Commission also sits on a number of committees including the Child Death Review Team, Eating Disorders Strategy Implementation Committee, Uniting Recovery Eating Disorder Resource Advisory Committee, Joint Protocol Committee to reduce the contact of young people in residential out of home care with the criminal justice system and the Juveniles Justice Advisory Committee.

### How it's improving mental health and wellbeing and the mental health system

A community that seeks out and values the views and needs of children and young people is in a far stronger position to ensure the provision of the type of care and support those children need to go onto live health and fulfilling lives as contributing members of society. Building the evidence base, and advocating to inquiries and reviews on the mental health and wellbeing from the earliest years and collaborating with others, strengthens the responses to the needs of this population group and their families.

## Disability inclusion

### The goal

People with severe and persistent mental illness, including psychotic disorders, often also experience psychosocial disability. Psychosocial disability is not well understood and is often overlooked. The Commission works with relevant stakeholders to promote the rights, views and inclusion of people who experience psychosocial disability.

### What the Commission has done

- The Commission has undertaken a broad range of activities to monitor the implementation of the NDIS for people with a psychosocial disability and to advocate for their views and needs. From June 2013 the Commission partnered with the Mental Health Coordinating Council (MHCC) in employing an officer at the Hunter National Disability Insurance Scheme launch site to monitor the implementation of the NDIS. This work led to the establishment of a Community of Practice with regular forums where public sector agencies,

community managed organisations, consumers and carers share their experiences and hear from key organisations. The MHCC developed a report including findings and recommendations to improve outcomes for people affected by mental health issues. This report has informed the Commission's advice to government and National Disability Insurance Agency (NDIA).

- The Commission continues to engage with the NDIA and relevant state agencies in relation to the NDIS roll-out and what this means for people with psychosocial disability and their families and carers. This has included hosting a number of forums across the state (including one on behalf of Health in late 2015) and developing resources including a video *NDIS – mental health perspectives*, which depicts the experiences of Debbie and Daniel, participants in the NDIS and the role of Daniel's mother.
- The Commission has also contributed through more formal mechanisms regarding the roll out of the NDIS including: having input into the development of the NDIS Quality and Safeguarding Framework by the Commonwealth; representing the combined Australian mental health commissions on the NDIA National Mental Health Sector Reference Group; providing a written submission to the Commonwealth Joint Standing Committee on the NDIS on the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition as well as the Commissioner giving oral evidence to a Committee hearing.
- The Commission also works with consumers and carers to ensure that the NDIS changes and opportunities are well understood across the whole community.
- The Commission partnered in a project led by the UNSW and funded by the National Health and Medical Research Council focused on improving the mental health outcomes of people with intellectual disability. The project included data linkage to better understand current access to mental health services by people with an intellectual disability, and a review of current policy at a national and state level.
- The Commission has provided a number of submissions on initiatives connected to disability inclusion planning, to ensure that the views and needs of people with psychosocial disability are included. The Commission provided submissions to the Commonwealth inquiry into the delivery of outcomes under the National Disability Strategy 2010 – 2020 to build inclusive and accessible communities and on the City of Sydney's draft disability inclusion plan. The Commission also sits on the NSW Disability Inclusion Action Plan Implementation Committee.
- The Commission works closely with partners including the Public Service Commission, Family and Community Services and Way Ahead to advocate for best practice in policy and processes to support employment for people with lived experience of mental illness.

### How it's improving mental health and wellbeing and the mental health system

Ensuring the views of people who experience psychosocial disability are heard and respected ensures that the many developments taking place in relation to disability inclusion are broad enough to encompass their specific needs.

## Research

### The goal

To engage with research bodies to bring about alignment between research programs and the reform directions identified in *Living Well.* Overtime, this will produce a strong evidence base to guide policy, program and service development.

### What the Commission has done

- The Commission supported the University of Sydney and the UNSW to develop a partnership in mental health, addiction and neuroscience, formalised through a Memorandum of Understanding (MoU). As part of the Commission's role in supporting research and innovation, Sarah Hanson, Executive Officer, was seconded jointly by the universities for six months to provide strategic advice to the Steering Committee established to put the MoU into practice, scoping the inaugural operational plan and initial priority projects and was subsequently invited to join the universities' steering committee to provide ongoing advice.
- Since 2015 the Commission has provided secretariat support to the Consumer Led Research Network. The Network was established to promote, support and undertake consumer led research activities in NSW. The Commission is currently supporting the Network in establishing formal relationships with research institutions.
- In partnership with the MHCC and the Network of Alcohol and other Drugs Agencies the Commission supports the work of the Community Mental Health Drug and Alcohol Research Network, which was established to broaden the involvement of community mental health and alcohol and other drugs sector in practice-based research to and promote the value of research and the use of research evidence in practice.
- To foster a collaborative approach in the research space the Commission has entered into memoranda of understanding with the University of Newcastle and the Aboriginal Health and Medical Research Council.
- As in other areas, the Commission always seeks to influence good practice in relation to policy development, the Commission provided a submission on the redesign of the University of Sydney's Medical School curriculum and sat on the panel for the Medical Research Future Fund. The Commission maintains close working relationships with leading research bodies across the state including the Black Dog Institute, the Brain and Mind Centre, the Hunter Institute for Mental Health, the Universities of Wollongong and Newcastle.

### How it's improving mental health and wellbeing and the mental health system

Through our ongoing collaborations with research bodies we have shifted the priorities informing current research programs and the conversations around this. It will take time for the evidence base to emerge from this shift. In particular, the MoU between Sydney University and UNSW has great potential to maximise the impact and benefits of the universities' research on systems, services and policies to enable mental health and wellbeing of both individuals and the community.

## Beyond NSW

### The goal

Mental health is a shared responsibility of the Commonwealth and state so we need to look at issues beyond our borders if we are to improve the mental health system and the mental health and wellbeing of the people of NSW.

### What has the Commission done

- On behalf of Australia, the Commission hosted the International Initiative for Mental Health Leadership week-long Leadership Exchange in Sydney in February 2017. The Exchange attracted over 300 international experts in mental health who participated in two day meetings on specific topics with local mental health leaders, before converging for a two day conference exploring the theme of *contributing lives, thriving communities.*
- Alongside the IIMHL, the Commission partnered with the National Mental Health Commission to provide two day knowledge exchange training course, known as Supporting the Promotion of Activated Research and Knowledge (SPARK), to emerging mental health leaders from across the country. SPARK focuses on bringing evidence informed innovations in mental health more rapidly into practice. The training was delivered by the Canadian Mental Health Commission.
- Former Deputy Commissioner, Bradley Foxlewin chaired the national Core Reference Group, formed in 2013 to oversee the National Seclusion and Restraint Project led by the National Mental Health Commission. This resulted in *A Case for Change: A Position Paper on seclusion, restraint and restrictive practices in mental health services.* This looked at best practice in reducing and eliminating seclusion and restraint of people with mental health issues and identified good practice approaches.
- The Commission has also participated in the Australian Human Rights Commission's consultations with civil society in relation to Australia's ratification of the Optional Protocol to the Convention against Torture through roundtable discussions and providing submissions on the consultation paper. On those issues that cut across jurisdictions the Commission has contributed to a consensus statement with the other mental health commissions of

Australia, in addition to providing its own submission on those issues specific to NSW.

- As noted above, the Commission took the lead on developing a consensus statement on behalf of the mental health commissions of Australia to the Royal Commission into Institutional Responses to Child Abuse.
- Since 2013, the Commission has provided administrative and strategic support to the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH), which provides advocacy advice and leadership to help restore, maintain and promote the social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander peoples. NATSILMH is financially supported by the NSW, Queensland, Western Australian and National mental health commissions. The Commission also supported NATSILMH in its development of the *Gayaa Dhuwi (Proud Spirit) Declaration*, which was launched in August 2015, calling for increased Indigenous leadership in Australia's mental health system.
- There are many changes taking place at both a Commonwealth and state level that impact the mental health system in NSW. The Commission has proactively engaged with Commonwealth bodies, such as Primary Health Networks to ensure that we can harness these changes for the best to ensure a joined up service system that provides the best support for people with mental illness in or close to their homes.

### How it's improving mental health and wellbeing and the mental health system

By partnering with other states and territories to develop common positions the Commission is able to maximise its impact and avoid unnecessary duplication of effort.

## Mental Health Grants Program

### Goal

To support key peak and advocacy bodies to represent the views and needs of consumers, carers and to promote innovative mental programs and supports.

### What the Commission has done

- We provide $1.2 million to beyondblue, a national non-government organisation working to reduce the impact of depression, anxiety and suicide in the community by raising awareness and understanding. We work with beyondblue to influence its work program and ensure it aligns with NSW priorities.
- The Mental Health Grants Program provides funding to three NSW based community managed organisations:

- Being, the mental health consumer representative peak body for NSW. Its work under the grant provided by the Commission includes:
    - Ensuring that consumers participate in policy and service delivery decisions that impact them with representation on government and non-government committees.
    - Organisation of the annual Consumer Worker Forum that brings together the state's public mental health peer workers to share ideas and identify best practice to ensures services throughout the state.
    - As well as a range of more specific projects such as a three part video resource in Arabic aimed to engage the Arabic- speaking communities in NSW on psychological health, distress and seeking health developed in 2016, and representation on the NSW Mental Health Commission's Consumer Lived Experience Project Steering Group. Key insights from consultations undertaken by this group will inform the development of a Lived Experience Framework for consumer participation, influence, and leadership.

- Mental Health Carers NSW (MHCN), the mental health carers representative peak body for NSW. Its work under the grant provided by the Commission includes:
    - Consulting with people with lived carer experience across NSW in order to provide accurate and representative feedback including by facilitating the following active Peak Advisory Committees to focus on specific issues impacting the lives of different carer communities:
        - General Carer Peak Advisory Committee
        - Younger Persons Carer Peak Advisory Committee
        - Older Persons Carer Peak Advisory Committee
        - Alcohol & Drug Carer Peak Advisory Committee
    - Developing training, information resources and tools to equip carers to participate effectively in the care of their loved ones with events such as the NDIS Carer Forum.

- WayAhead, which provides mental health promotion programs and support services. Its work under the grant provided by the Commission includes:
    - Organising the annual Mental Health Month Awards and administration of the small grants program to assist the staging of mental health promotion activities during Mental Health Month
    - Expansion and maintenance of the WayAhead Directory of mental health services with over 6000 listings.
    - Expansion and coordination of the WayAhead Workplaces program which involves resourcing and supporting organisations to create healthy workplaces

        - Organising a number of free anxiety programs throughout the year including support groups, forums and the Small Steps program which delivers presentations to teachers and parents, raising awareness of anxiety in children.

- Collective Purpose is a collaborative venture of the three organisations - WayAhead Mental Health Association, Being and Mental Health Carers NSW. Collective Purpose is a collaborative, co-working space that has been designed to support individuals and organisations to achieve a greater impact. The Commission has a contract of agreement in place with WayAhead to coordinate this collaborative space and shared services.
- Funding provided to these three organisations supports direct consumer and carer engagement in mental health policy and program design and promotion of innovative mental health supports.
- In 2016 -17, the Commission reviewed the grant arrangements with Being, Mental Health Carers NSW and WayAhead. The review examined specific programs of work funded under the grants program to enhance governance, effectiveness and business processes, as well as funding arrangements and grants management. The results of the review are currently under consideration to ensure that the mental health grants program is still meeting the needs of consumers and carers, and is configured to ensure administrative and contract arrangements are both efficient and effective

**How it's improving mental health and wellbeing and the mental health system**

These collaborations assist the Commission to fulfil several of its core functions under the Act to engage and consult with people who have a mental illness, and their families and carers, to advocate for the prevention of mental illness and promote good mental health and to educate the community about mental health issues.

# Appendix One

**Legend**
R = Report Tabled in Parliament
C = Priority as set out in the Mental Health Commission of NSW Charter
○ = Primary Function
● = Secondary Function
○ = Principle

| | | Functions according to the Act | | | | | | | | | | | | | | Principles according to the Act | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 12 (1)(a) | 12 (1)(b) | 12 (1)(c) | 12 (1)(d) | 12 (1)(e) | 12 (1)(f) | 12 (1)(g) | 12 (1)(h) | 12 (2)(b) | 12 (2)(c) | 12 (2)(d) (i) | 12 (2)(d) (ii) | 12 (2)(d) (iii) | 12 (2)(e) | 11 (a) | 11 (b) | 11 (c) | 11 (d) | 11 (e) (i) | 11 (e) (ii) |
| **Initiative** | **Date** | | | | | | | | | | | | | | | | | | | | |
| C Living Well: A Strategic Plan for Mental Health in NSW 2014-2024 | 2014 | ○ | | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ |
| R Living Well: A Report | 2014 | ○ | | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ |
| C Living Well in Our Community | 2013 | ○ | | | | | | | | | | | | | | ○ | ○ | ○ | ○ | ○ | ○ |
| Papers in support of *Living Well* | 2013-2014 | ○ | | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ |
| C Program of community visits | 2013- Ongoing | | ○ | | ● | | | | | | | | | | ● | ○ | ○ | ○ | ○ | ○ | ○ |
| R One Year On | 2015 | | ○ | | ● | ● | ● | ● | | ● | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ |
| Papers in support of ***One Year On*** | 2015 | | ○ | | ● | ● | ● | ● | | ● | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ |
| Submissions for Inquiries | 2012- Ongoing | | | ○ | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ○ | ○ | ○ | ○ | ○ | ○ |
| R Institute of Psychiatry (IoP) review and transition oversight | 2013-2017 | | | ○ | | ● | | | | | | | | | | | | | ○ | ○ | ○ |
| Medications and Mental Illness Workstream | 2014-2017 | | | ○ | ● | | | ● | | ● | | ● | ● | ● | ● | ○ | ○ | ○ | ○ | | ○ |
| R Towards a just system: Mental illness and cognitive impairment in the criminal justice system: directions for action | 2016-2017 | | | ○ | ● | | | | | ● | ● | | | | | ○ | ○ | ○ | ○ | ○ | ○ |
| R Funding review | 2017 | | | ○ | | | | | | | | | | | | ○ | ○ | ○ | ○ | ○ | ○ |
| Community Managed Organisations (CMOs) Review (underway) | 2017 | | | ○ | | | | | | | | ● | ● | ● | | ○ | ○ | | ○ | | |
| Recovery into Practice Forum | 2013 | | | | ○ | | | | | | ● | | | | | ○ | ○ | ○ | ○ | ○ | ○ |
| Mental Health Review Tribunal Recovery Forum | 2013 | | | | ○ | | | ● | | | | | | | | ○ | ○ | ○ | ○ | ○ | ○ |
| Establishment of National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) | 2013 | | | | ○ | | | | | | | | | | ● | ○ | ○ | ○ | ○ | ○ | ○ |
| Trauma Informed Care and Practice Forum and Workshop | 2013-2014 | | | ● | ○ | | ● | | | | | | | | | ○ | ○ | ○ | ○ | ○ | ○ |
| Building the Community Sector Forum | 2014 | | | | ○ | | | | ● | | | | | | | | | | ○ | ○ | |
| Police Mental Health Intervention Training Evaluation | 2014 | | | | ○ | | | | | | ● | | | | | ○ | ○ | ○ | ○ | ○ | ○ |
| Police Mental Health Intervention Training Videos | 2014 | | | | ○ | | | | | | ● | ● | | | | ○ | ○ | ○ | ○ | ○ | ○ |
| Facilitating communication in the criminal justice system (witness intermediaries) | 2015 | | | | ○ | | | | | | ● | | | | | | ○ | | ○ | ○ | |
| 'Open Dialogue', Dr Christopher Gordon and Brenda Miele Soares | 2015 | | | | ○ | | | ● | ● | | | | | | | ○ | ○ | ○ | ○ | ○ | ○ |
| 'Wraparound Milwaukee', Bruce Kamradt | 2015 | | | | ○ | | ● | | | | | | | | | ○ | ○ | ○ | ○ | ○ | ○ |
| Wellbeing Collaborative | 2015-2016 | | | | ○ | ● | | ● | | | | | | | | | | | ○ | ○ | |
| Health Justice Partnerships (HJPs) | 2015 - Ongoing | | | | ○ | ● | | ● | ● | | | | | | | | ○ | | ○ | ○ | |
| 'Slow Psychiatry', Dr Sandra Steingard | 2016 | | | | ○ | | | | ● | | | | | | | ○ | ○ | ○ | ○ | ○ | ○ |
| Promoting Mentally Healthy Cities, Dr Arthur Evans | 2016 | | | | ○ | | | | ● | | | | | | | | ○ | | | ○ | |
| Trauma Project on Australia News Media Depictions of Child Sexual Abuse | 2016- Ongoing | | | | ○ | | | | ● | | | | | | | | ○ | | | ○ | |
| C International Initiative in Mental Health Leadership (IIMHL) Exchange | 2017 | | | | ○ | | | ● | | | | | | | | ○ | ○ | ○ | ○ | ○ | ○ |

**Legend**
R = Report Tabled in Parliament
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● = Primary Function
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| | | Functions according to the Act | | | | | | | | | | | | | | Principles according to the Act | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 12 (1)(a) | 12 (1)(b) | 12 (1)(c) | 12 (1)(d) | 12 (1)(e) | 12 (1)(f) | 12 (1)(g) | 12 (1)(h) | 12 (2)(b) | 12 (2)(c) | 12 (2)(d) (i) | 12 (2)(d) (ii) | 12 (2)(d) (iii) | 12 (2)(e) | 11 (a) | 11 (b) | 11 (c) | 11 (d) | 11 (e) (i) | 11 (e) (ii) |
| **Initiative** | **Date** | | | | | | | | | | | | | | | | | | | | |
| Community Mental Health Drug and Alcohol Research Network (CMHDARN) | 2013-2017 | | | | ● | ● | | | | ● | | | | | | | | | ● | ● | ● |
| Improving Mental Health and Wellbeing of People with Intellectual Disability (underway) C | 2013-2017 | | | | ● | ● | | ● | | ● | | | | | | ● | ● | ● | ● | | ● |
| Mental Health and Homelessness Report | 2013 | | | | | ● | | ● | | | | | | | | ● | ● | ● | ● | ● | ● |
| Communities matter C | 2013- Ongoing | | | | | ● | | ● | ● | | | | | | ● | ● | ● | ● | ● | ● | ● |
| Conversations matter | 2013- Ongoing | | | | | ● | | ● | ● | | | | | | ● | ● | ● | ● | ● | ● | ● |
| Promotion, prevention and early intervention evidence guide | 2014 | | | | | ● | ● | | | | | | | | | | | ● | ● | | |
| Supporting Your Friends Research Project - Support in Tough Times | 2014 | | | | | ● | | | ● | | | | | | | ● | ● | ● | ● | ● | ● |
| NSW Electroconvulsive Therapy (ECT) Research Network | 2014-2015 | | | | | ● | | | ● | | | | | | | ● | ● | ● | ● | ● | ● |
| Review of the NSW Population Health Survey | 2014-2015 | | | | ● | ● | | ● | | | | | | | | | | ● | | | |
| Measuring Consumer Experiences of Care – the Your Experiences of Services (YES) information technology pilot | 2014-2015 | | | | | ● | | | | | | ● | ● | ● | | ● | ● | ● | | | ● |
| Consumer Led Research Network (CLRN) | 2014- Ongoing | | | | ● | ● | | | | | | ● | ● | ● | | | ● | | | | ● |
| iBobbly | 2015 | | | | | ● | ● | | | | | | | | | ● | | ● | | | ● |
| ReachOut.com - Pathways to Mental Health Care in Western NSW C | 2015 | | | | | ● | ● | | | | | | | | | ● | | ● | | ● | |
| LHD Seed grants | 2015 | | | | ● | ● | ● | ● | | | | | | | ● | ● | ● | ● | ● | ● | ● |
| National Surveys of Mental Health Literacy and Stigma- Analysis of NSW Results | 2015 | | | | ● | ● | | ● | ● | | | | | | | | ● | | ● | | |
| Synergy Online Ecosystem Trial C | 2015-2016 | | | | | ● | ● | | | | | | | | | ● | | ● | | ● | |
| Far West NSW Atlas | 2015-2016 | | | | | ● | | | | | | | | | ● | ● | | | ● | | |
| Living Well in Later Life | 2015- 2017 | | | | ● | ● | | ● | ● | | | | | | | ● | ● | ● | ● | ● | ● |
| Justice data linkage project | 2015- 2017 | | | | ● | ● | | ● | | | ● | | | | | | | | | ● | |
| Peer work hub C | 2015- Ongoing | | | | ● | ● | | | | | | ● | ● | ● | | ● | ● | ● | ● | ● | ● |
| Suicide Prevention Workstream | 2015- Ongoing | | | | | ● | | ● | | | | | | | | ● | ● | ● | ● | ● | ● |
| Butterfly Insights in Recovery Report | 2015-2016 | | | | ● | ● | | ● | | | | ● | ● | ● | | | ● | ● | | ● | ● |
| Physical health and mental wellbeing evidence guide | 2016 | | | | | ● | ● | | | | | | | | | | | ● | | | |
| Effectiveness of Services Led and Run by Consumers Review | 2016 | | | | ● | ● | | | | | | | | | | | | | ● | | ● |
| Mental Health and Wellbeing Strategy for NSW First Responder Organisations | 2016 | | | | ● | ● | | ● | ● | | | ● | ● | ● | | | ● | | ● | | ● |
| Coronial data analysis | 2016-2017 | | | | ● | ● | | ● | | | | | | | | ● | | | | ● | |
| Lived Experience Steering Group and Framework (underway) | 2016-2017 | | | | ● | ● | | | | | | | | | | ● | ● | ● | ● | ● | ● |
| Recovery and justice | 2016- 2017 | | | | ● | ● | | | | | ● | | | | ● | | | | ● | ● | |
| Forensic patients database | 2016- Ongoing | | | | ● | ● | | | | | ● | | | | | | | | ● | | |
| Mapping Social and Emotional Wellbeing policies | 2017 | | | | ● | ● | | | | | | | | | ● | ● | | | | | |
| Disability inclusion C | 2012- Ongoing | | | | | | ● | ● | | ● | | | | | | ● | ● | ● | ● | ● | ● |
| National Disability Insurance Scheme (NI Advocacy C | 2013-Ongoing | | | | | | ● | ● | | ● | | | | | | ● | ● | ● | ● | ● | ● |
| Check up from the Neck Up | 2016-Ongoing | | | | ● | | ● | ● | | | | | | | | ● | ● | ● | ● | ● | ● |
| Suicide Data Improvement Project | 2016 - Ongoing | | | | | | ● | ● | | | | | | | | ● | ● | ● | ● | ● | ● |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 12 (1)(a) | 12 (1)(b) | 12 (1)(c) | 12 (1)(d) | 12 (1)(e) | 12 (1)(f) | 12 (1)(g) | 12 (1)(h) | 12 (2)(b) | 12 (2)(c) | 12 (2)(d) (i) | 12 (2)(d) (ii) | 12 (2)(d) (iii) | 12 (2)(e) | 11 (a) | 11 (b) | 11 (c) | 11 (d) | 11 (e) (i) | 11 (e) (ii) |
| **Initiative** | **Date** | | | | | | | | | | | | | | | | | | | | |
| Undertaking key proactive media relations to raise awareness and reduce stigma | 2012-Ongoing | | | | ● | | | ● | ● | | | | | | | ● | ● | ● | ● | ● | ● |
| Ensuring the voices of consumers and carers are heard | 2012- Ongoing | | | | ● | | | | ● | | | ● | ● | ● | | ● | ● | ● | ● | ● | ● |
| Public Lecture | 2013 | | | | ● | | | | ● | | | | | | | ● | ● | ● | ● | ● | ● |
| C Youth Week Pop Up Website | 2014 | | | | ● | | ● | ● | ● | | | | | | | | ● | ● | | | ● |
| Youth Week Forum Minding Our Mental Health Forum | 2014 | | | | ● | | ● | ● | ● | | | | | | | | | ● | | | ● |
| No Offence...' | 2015 | | | | ● | | ● | ● | ● | | | | | | | | | ● | | | ● |
| Parliamentary Showcase | 2015- 2016 | | | | ● | | | | ● | | | | | | | ● | ● | ● | ● | ● | ● |
| Wellbeing Products | 2015- Ongoing | | | | ● | | ● | ● | ● | | | | | | | ● | ● | ● | ● | ● | ● |
| Living Well@Work | 2016 | | | | ● | | | ● | ● | | | | | | | ● | ● | ● | ● | ● | ● |
| Parliamentary Friends of Mental Health | 2016- Ongoing | | | | | | | ● | ● | | | | | | | ● | ● | ● | ● | ● | ● |
| C Growing Up Digital | 2017 | | | | ● | | ● | ● | ● | | | | | | | ● | ● | ● | ● | ● | ● |
| Living Well: Community Perspectives of Change | 2016 | | | | | ● | | | | | | ● | ● | ● | | | ● | | | | |

## Mental Health Commission – Five Year Review

Legend:

R Report Tabled in Parliament

C Priority as set out in the Mental Health Commission of NSW Charter

*A note on the navigation of this table: All activities have been grouped according to their primary function, and in date order within that function (with the exception of function 12 (1)(a).*

| What we did (activity/initiative) | Date | Primary Function in relation to the Act | Secondary Function(s) in relation to the Act | Principle in relation to the Act | Output | How we did it | Outcomes |
|---|---|---|---|---|---|---|---|
| ***Living Well:*** C<br>***A Strategic Plan for Mental Health in NSW 2014-2024***<br>• *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024* (*Living Well)* sets out directions for reform of the mental health system in NSW over the next 10 years from 2014- 2024. | **2014** | **12 (1)(a)** to prepare, in consultation with providers of mental health and related services and government agencies, a draft strategic plan for the mental health system in New South Wales for submission to the Minister for approval. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues.<br><br>**12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers.<br><br>**12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness.<br><br>**12 (2)(b)** to take into account co-morbid issues associated with mental illness, such as drug and alcohol use and disability.<br><br>**12 (2)(c)** to take into account issues related to the interaction between people who have a mental illness and the criminal justice system. | Principles 11 (a) through to 11 (e)(ii). | • *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024* | • The Mental Health Commission of NSW (the Commission):<br>- Consulted with over 2000 people across NSW, including 800 people with lived experience and carers.<br>- Forums were held with communities in Broken Hill, Kempsey, Tamworth, Nowra and Dubbo in order to understand more about the particular needs and experiences of people with mental illness who live outside metropolitan areas.<br>- Targeted engagement with community, consumers, carers, government, and Community Managed Organisation (CMO) sectors was carried out.<br>- A series of research papers were commissioned to inform the plan. | • *Living Well* was adopted in full as government policy in December 2014.<br>• *Living Well* aligned reform across government with a number of commonwealth, state, and community initiatives that complement *Living Well.* |

| What we did (activity/initiative) | Date | Primary Function in relation to the Act | Secondary Function(s) in relation to the Act | Principle in relation to the Act | Output | How we did it | Outcomes |
|---|---|---|---|---|---|---|---|
| | | | **12 (2)(d)** to engage and consult with:<br>(i) People who have a mental illness and their families and carers.<br>(ii) The government and non- government sectors.<br>(iii) The whole community. | | | | |
| **Living Well: A Report** R<br><br>A companion report to *Living Well;* this report details people's experiences, needs, wishes and priorities for mental health support and community wellbeing for specific advice for government.<br><br>(A report under Function **14(1)(a)**) | **2014** | **12 (1)(a)** to prepare, in consultation with providers of mental health and related services and government agencies, a draft strategic plan for the mental health system in New South Wales for submission to the Minister for approval. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues.<br><br>**12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers.<br><br>**12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness.<br><br>**12 (2)(b)** to take into account co-morbid issues associated with mental illness, such as drug and alcohol use and disability.<br><br>**12 (2)(c)** to take into account issues related to the interaction between people | Principles 11 (a) through to 11 (e)(ii). | • *Living Well: Putting people at the centre of mental health reform in NSW: A Report* | • The Commission travelled around the state of NSW, holding public meetings and barbecues in small and large towns and with Aboriginal communities, to hear the concerns of people from diverse cultural backgrounds.<br>• Based on common mental health experiences at different times of life, the Commission established working groups, in which people with expertise gained from living with mental illness joined academics and service providers develop ideas for how we could improve the system. | • The report presented a powerful case for a new generation of mental health reform in NSW, one that puts people firmly at the centre.<br>• The Mental Health Reform Implementation Taskforce (the Taskforce) was established in 2014 to oversee the implementation of *Living Well*.<br>• A number of government departments and agencies have undertaken activities as a result of the actions required in *Living Well* including the Department of Health NSW, the Department of Education NSW, and Police and Transport NSW.<br>• A number of community, state, and commonwealth initiatives are now underway that compliment *Living Well.*<br>- This report was submitted to the Minister for Mental Health and tabled in Parliament on 14 October 2014. |

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| | | | who have a mental illness and the criminal justice system.<br><br>**12 (2)(d)** to engage and consult with:<br>(i) People who have a mental illness and their families and carers.<br>(ii) The government and non- government sectors.<br>(iii) The whole community. | | | | |
| **Living Well in Our Community** C<br>• This is the first of two companion papers designed to set the scene for the development of a Strategic Plan for Mental Health in NSW. | **2013** | **12 (1)(a)** to prepare, in consultation with providers of mental health and related services and government agencies, a draft strategic plan for the mental health system in New South Wales for submission to the Minister for approval. | | Principles 11 (a) through to 11 (e)(ii). | • *Living Well in Our Community- Paper 1* | • This paper reflects on the issues and challenges raised with the Commission since its establishment in mid 2012.<br>• The paper sets out initial thoughts in relation to a vision and a set of principles to guide mental health reform in NSW. | • The paper provides a useful starting point for the process of reforming a NSW mental health system. |
| **Papers in support of *Living Well***<br>• The Commission commissioned a number of supporting research papers, to inform *Living Well.* | **2013 - 2014** | **12 (1)(a)** to prepare, in consultation with providers of mental health and related services and government agencies, a draft strategic plan for the mental health system in New South Wales for submission to the Minister for approval. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues.<br><br>**12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers.<br><br>**12 (2)(b)** to take into account co-morbid issues associated with mental illness, such as | Principles 11 (a) through to 11 (e)(ii). | • *Australia's international human rights obligations*<br>• *Broke systems: breaking people: A report on carer expectations of the NSW draft Strategic Plan for Mental Health*<br>• *Building Community Resilience and Wellbeing Report*<br>• *Carers and Community Needs*<br>• *Clinical services planning for adults with intellectual disability and co-occuring mental disorders*<br>• *Culturally and linguistically diverse (CALD) Research to assist with development of draft Strategic Plan*<br>• *Leaders Forum on Mental Health and CALD Communities*<br>• *Mental health and substance use: opportunities for innovative prevention and treatment*<br>• *NSW mental health services in context*<br>• *Primary Care Mental Health Strategy* | • The Commission partnered with a number of organisations to deliver a number of reports that would provide early insights to inform the *Living Well* reforms. | • The research papers contributed to the evidence base of *Living Well* reforms. |

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| | | | drug and alcohol use and disability.<br><br>**12 (2)(c)** to take into account issues related to the interaction between people who have a mental illness and the criminal justice system.<br><br>**12 (2)(d)** to engage and consult with:<br>(i) People who have a mental illness and their families and carers.<br>(ii) The government and non- government sectors.<br>(iii) The whole community. | | • *Strategies for adopting and strengthening e-mental health*<br>• *Telling it like it is: Community Report*<br>• *Towards a Mental Health Strategy for NSW: Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) Community Consultations*<br>• *Trauma-informed care and practice: Forum report and evaluation*<br>• *Views of the NSW Refugee Health Improvement Network*<br>• *A rapid review of the evidence on the costs and impacts on the economy and productivity due to mental ill health*<br>• *A rapid review of economic modelling of the costs and benefits of interventions in the areas of mental health* | | |
| **Program of community visits** C<br><br>• Since 2013, the Commission has held a series of forums with communities in regional towns across NSW in order to understand more about the particular needs and experiences of people with mental illness who live outside metropolitan areas.<br>• The feedback from the forums informed the Commission's subsequent recommendations for the reform of the mental health system. | **2013-Ongoing** | **12 (1)(b)** to monitor and report on the implementation of the strategic plan. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (2)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | Principles 11 (a) through to 11 (e)(ii). | • Community forums and visits. | • Visit teams are established from across the Commission and include the Commissioner and/ or Deputy Commissioners.<br>• In 2015 there were visits to: Broken Hill, Wagga Wagga, Griffith, Coffs Harbour, Kempsey, Queanbeyan, Goulburn and Bega to gauge and promote awareness of *Living Well*.<br>• In 2016 there were visits to selected metropolitan health districts for a series of visits, due to their relative proximity, including: Central Coast, Nepean Blue Mountains, Western Sydney, South Western Sydney, Port Stephens and Newcastle.<br>• In 2017 there were visits to Orange, | • During the community visits the following outcomes were measured:<br>- Key teams from the Commission met with over 3000 people during the visits, with over 200 personnel from NSW government agencies.<br>- Over 100 views of the eleven Community visits 2015 videos.<br>- Reports produced for each visit and sent to stakeholders.<br>- More than 20 forums and information sessions held across NSW.<br>• The launch of Wellbeing Collaborative was part of 2016 visits.<br>• The feedback from the forums informed the Commission's subsequent *Living Well* actions. |

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| | | | | | | Clearance Valley, and Grafton.<br>• Districts were used as case studies of good practice and to document enablers and barriers to reform, where relevant. | |
| **One Year On** R<br><br>• The Commission developed the first report to the Minister for Mental Health on progress on the implementation of *Living Well.*<br>• The resulting report, *One Year On*, made 13 recommendations about where more effort was required to implement the actions from *Living Well*, or to establish the platform upon which future reform could be built.<br>(A report under Function **14(1)(b)**) | **2015** | **12 (1)(b)** to monitor and report on the implementation of the strategic plan. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues.<br><br>**12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers.<br><br>**12 (2)(b)** to take into account co-morbid issues associated with mental illness, such as drug and alcohol use and disability.<br><br>**12 (2)(c)** to take into account issues related to the interaction between people who have a mental illness and the criminal justice system.<br><br>**12 (2)(d)** to engage and consult with:<br>(i) People who have a mental illness and their families and carers.<br>(ii) The government and non- government sectors.<br>(iii) The whole community. | Principles 11 (a) through to 11 (e)(ii). | • *One Year On: Progress Report on the implementation of Living Well: A Strategic Plan for Mental Health in NSW 2014 – 2024* | • The Commission carried out a review process which considered government agencies; a survey of the community; and assessed data against the 10 *Living Well* indicators. | • The report identified that leadership in government and services was reported as both the main strength to reform and, where it was inadequate, was the greatest barrier to reform.<br>• The report provided baseline information for continued measurement of the Commission's 10 key performance indicators of mental health reform.<br>• This report was submitted to the Minister for Mental Health and tabled in Parliament on 24 February 2016 and was accompanied by a series of supporting papers. |

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| **Papers in support of *One Year On***<br>• The Commission commissioned a number of supporting research papers, to inform *One Year On.* | **2015** | **12 (1)(b)** to monitor and report on the implementation of the strategic plan. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues.<br><br>**12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers.<br><br>**12 (2)(b)** to take into account co-morbid issues associated with mental illness, such as drug and alcohol use and disability.<br><br>**12 (2)(c)** to take into account issues related to the interaction between people who have a mental illness and the criminal justice system.<br><br>**12 (2)(d)** to engage and consult with:<br>(i) People who have a mental illness and their families and carers.<br>(ii) The government and non- government sectors.<br>(iii) The whole community. | Principles 11 (a) through to 11 (e)(ii). | • Supporting papers to *One Year On:*<br>- *Government agencies advice to the Commission on progress*<br>- *The Work of the Mental Health Reform Implementation Taskforce*<br>- *Baseline analysis of the 10 Living Well indicators*<br>- *Findings of the Commission's Ready for Change community survey*<br>- *Examples of Reform Initiatives and Innovative Practice across NSW*<br>- *An overview of policy changes affecting mental health since the launch of Living Well in December 2014* | • The Commission worked with a number of organisations to provide the information that would provide insights to inform *One Year On*. | • The papers contributed to the evidence base of *One Year On* progress reporting. |
| **Submissions for Inquiries**<br>• The Commission provided a number of submissions to different government organisations requiring expert input on mental health in NSW. | **2012-Ongoing** | **12 (1)(c)** to review and evaluate, and report and advise on, mental health services and other services and programs provided to people who have a mental illness, and other issues | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(e)** to undertake and commission research, | Principles 11 (a) through to 11 (e)(ii). | • *Disability employment services*<br>• *City of Sydney Disability Inclusion Action Plan*<br>• *Homelessness in NSW*<br>• *Youth Health Policy Consultation* | • The Commission has provided a number of submissions in response to requests from government agencies in its capacity for monitoring, reviewing | • The submissions provided to other government agencies<br>• Many of the recommendations have been adopted. |

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| | | affecting people who have a mental illness. | innovation and policy development in relation to mental health issues.<br><br>**12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers.<br><br>**12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness.<br><br>**12 (2)(a)** to focus on systemic mental health issues.<br><br>**12 (2)(b)** to take into account co-morbid issues associated with mental illness, such as drug and alcohol use and disability.<br><br>**12 (2)(c)** to take into account issues related to the interaction between people who have a mental illness and the criminal justice system.<br><br>**12 (2)(d)** to engage and consult with:<br>(i) People who have a mental illness and their families and carers.<br>(ii) The government and non- government sectors.<br>(iii) The whole community.<br><br>**12 (2)(e)** to take into account the particular views and needs of different sections of the | | • *Delivery of outcomes under NDIS*<br>• *Provision of services under NDIS*<br>• *Review of the Guardianship Act*<br>• *Review of the Coroners Act (in confidence)*<br>• *Mental Health Act Review*<br>• *Indefinite detention of people with cognitive and psychiatric impairment in Australia*<br>• *Redesign of University of Sydney Medical School curriculum*<br>• *Art and mental health*<br>• *Mental health recovery and social housing*<br>• *NSW Treasury, draft Internal Audit and Risk Management Policy*<br>• *Commonwealth Department of Health, Issues Paper on Clozapine*<br>• *A response to the National Safety and Quality Health Standards Review: Standard MS: Medication safety*<br>• *FaCS, Targeted Early Intervention Program Reform*<br>• *Health, Draft NSW Perinatal Mental Health Mother-Baby Unit Model of Care*<br>• *Submission to the Australian Human Rights Commission on their Optional Protocol to the Convention against Torture and other Cruel (OPCAT) Consultation Paper*<br>• *Submission to the Royal Commission on Child Sexual Abuse*<br>• *Social Services Legislation Bill*<br>• *NSW Youth Health Policy*<br>• Draft Fifth National Mental Health Plan | and improving mental health and wellbeing for people in NSW. | |

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| | | | community, including Aboriginal communities, culturally and linguistically diverse communities and regional and remote communities. | | | | |
| **Institute of Psychiatry (IoP) review and transition oversight** R<br>• The Commission conducted a functional review of the IoP, resulting in a report to the Minister in August 2013.<br>• The review concluded that there was a need to maintain high quality training and professional development for the mental health workforce and recommended that the IoP be aligned with the mainstream health education sector to maximise opportunities for shared education and training and integrated governance and planning.<br><br>(A report under Function **13(1)**) | **2013-2017** | **12 (1)(c)** to review and evaluate, and report and advise on, mental health services and other services and programs provided to people who have a mental illness, and other issues affecting people who have a mental illness. | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **11 (d)** the promotion of good mental health and the effective provision of mental health services are the shared responsibility of the government and non-government sectors.<br><br>**11 (e)(i)** an effective mental health system requires a coordinated and integrated approach across all levels of government and the non-government sector, including in the areas of health, housing, employment, education and justice.<br><br>**11 (e)(ii)** an effective mental health system requires communication and collaboration between people who have mental illness and their families and carers, providers of mental health services, and the whole community. | • *Review NSW Institute of Psychiatry* | • The Commission undertook a functional review of the NSW IoP with the support of a consultant, Dr. Tim Smyth. The review took into account its functions as stipulated by the Act and with regards to other organisations in this space.<br>• Meetings were held with senior staff of the IoP and other organisations. | • The recommendations were accepted and a staged transition process commenced in January 2014 with the administrative integration of IoP within Health Education and Training Institute (HETI).<br>• The successful transition was implemented over three years, oversighted by a transition committee, chaired by the NSW Mental Health Commissioner John Feneley (the Commissioner), and was completed in February 2017. |
| **Medications and Mental Illness Workstream**<br>• In response to concerns raised in community consultations undertaken for *Living Well* about the increasing reliance on the use of medication as a treatment for mental illness, the Commission undertook to review the issue.<br>• The Commission developed a perspectives paper, an insights guide and a suite of resources (videos and postcards) to help clinicians and people with | **2014 – 2017** | **12 (1)(c)** to review and evaluate, and report and advise on, mental health services and other services and programs provided to people who have a mental illness, and other issues affecting people who have a mental illness. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(g)** to advocate for and promote the general health and wellbeing of people who have mental illness and their families and carers.<br><br>**12 (2)(b)** to take into account co-morbid issues associated with mental illness, such as drug and alcohol use and disability. | **11 (a)** people who have a mental illness, wherever they live, should have access to the best possible mental health care and support.<br><br>**11 (b)** people who have a mental illness and their families and carers should be treated with respect and dignity.<br><br>**11(c)** the primary objective of the mental health system should be to support people who have a mental illness to | • *Medication and Mental Illness: Perspectives*<br>• Accompanying video resources.<br>• A postcard-size Consumer Discussion Guide was distributed to 1950 pharmacist locations and 189 neighbourhood centres in rural NSW. | • In February 2014 the Commission established an expert Pharmacotherapy in Mental Health Advisory Group.<br>• In November 2014 the Commission published an issues paper on medication and mental illness, which opened a month-long call for submission, where more than 200 submissions were received. | • The perspectives paper showed that there needs to be a balanced approach to the question of medication, for some people it is essential to their recovery and for others it has been a negative experience.<br>• The activities in this workstream served to increase awareness among GPs and Pharmacies regarding medications and mental illness. |

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| experience of mental illness to discuss the issue of medication.<br>• A survey consultation is currently being undertaken on the postcard initiative. | | | **12 (2)(d)** to engage and consult with:<br>(i) People who have a mental illness and their families and carers.<br>(ii) The government and non- government sectors.<br>(iii) The whole community.<br><br>**12 (2)(e)** to take into account the particular views and needs of different sections of the community, including Aboriginal communities, culturally and linguistically diverse communities and regional and remote communities. | participate fully in community life and lead meaningful lives.<br><br>**11 (e)(ii)** an effective mental health system requires communication and collaboration between people who have mental illness and their families and carers, providers of mental health services, and the whole community. | | • In 2015 the Commission held consultations with Aboriginal health workers, young people, older people and Cultural and Linguistically Diverse (CALD) representatives. | |
| **Towards a just system: Mental illness and cognitive impairment in the criminal justice system: directions for action** R<br>• The Commission liaised closely with leading academics and sector representatives to review the issue of the criminal justice system response to people with mental health issues or cognitive impairment.<br><br>(A report under Function **14(1)(e)**) | **2016-2017** | **12 (1)(c)** to review and evaluate, and report and advise on, mental health services and other services and programs provided to people who have a mental illness, and other issues affecting people who have a mental illness. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (2)(b)** to monitor and report on the implementation of the strategic plan.<br><br>**12 (2)(c)** to take into account issues related to the interaction between people who have mental illness and the criminal justice system. | Principles 11(a) through to 11 (e)(ii). | • *Towards a just system: Mental illness and cognitive impairment in the criminal justice system: directions for action* | • Guided by an Expert Advisory Group, the Commission looked at past recommendations, assess progress to date and identified what is required to move this issue forward.<br>• A consultation paper was developed for circulation among a broad range of stakeholders, including relevant government agencies. | • The launch of this review was held at Parliament House on 27 July 2017. |
| **Funding review** R<br>The Commission undertook a review of transparency and accountability of mental health funding in NSW.<br><br>(A report under Function **14(1)(d)**) | **2016-2017** | **12 (1)(c)** to review and evaluate, and report and advise on, mental health services and other services and programs provided to people who have a mental illness, and other issues affecting people who have a mental illness. | | Principles 11(a) through to 11 (e)(ii). | • The report was submitted. | • The Commission undertook a review with the support of two consultants, working closely with the Ministry of Health and using four LHDs (Hunter New England, North Sydney and Western Sydney, and Western NSW) as examples of funding mechanisms in NSW.<br>• The Commission consulted with other relevant government agencies including the | • The funding review has shone a light on the complexity of mental health funding arrangements and the need for clarity in relation to the purchasing framework. |

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| | | | | | | Treasury and the Audit Office. | |
| **Community Managed Organisations (CMOs) Review (underway)**<br>• The Commission conducted independent review of key partner NGOs that focused on appropriateness, governance, management, effectiveness, efficiency and sustainability.<br>• Recommendations provided guidance to Commission and NGOs on how best to align their funded activities with the Living Well Plan and the Commission's functions. | **2017** | **12 (1)(c)** to review and evaluate, and report and advise on, mental health services and other services and programs provided to people who have a mental illness, and other issues affecting people who have a mental illness. | **12 (2)(d)** to engage and consult with:<br>(i) People who have a mental illness and their families and carers.<br>(ii) The government and non- government sectors.<br>(iii) The whole community. | **11 (a)** people who have a mental illness, wherever they live, should have access to the best possible mental health care and support.<br><br>**11 (b)** people who have a mental illness and their families and carers should be treated with respect and dignity.<br><br>**11 (d)** the promotion of good mental health and the effective provision of mental health services are the shared responsibility of the government and non-government sectors. | • CMO Review. | • The Commission undertook a review with the support of a consulting team, to carry out the review and to get buy-in from stakeholders and key partner NGOs (performance managed by the Commission). | • There was clear agreement from organisations that the review has helped them improve their delivery of funded activities.<br>• The outcomes of the review will guide the next four years of funding and contract agreements with CMOs. |
| **Recovery into Practice Forum**<br>• The forum explored how recovery principles can be incorporated into the practice of mental health care and support.<br>• Participants included clinical and service leaders from government and CMOs working in mental health support and from other sectors including community services, justice and law enforcement. | **2013** | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | **12 (2)(c)** to take into account issues related to the interaction between people who have mental illness and the criminal justice system. | Principles 11(a) through to 11 (e)(ii) | • One day forum | • The forum featured international guest speaker John Jenkins President of the International Mental Health Collaborating Network, who has worked in community mental health development in the UK for 45 years.<br>• John Jenkins and his UK colleagues, John Stacey and Paul Baker, provided examples of international best recovery practice and agendas for change.<br>• Facilitator, Leanne Craze also presented the national framework for recovery oriented mental health services in terms of policy and practitioners.<br>• Delegates also heard from Deputy Commissioner Robyn Shields on 'What's important for Aboriginal people', Associate | • The forum provided an opportunity for key stakeholders to highlight and share the importance of recovery oriented practice at the core of all service provision. |

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| | | | | | | Professor Beth Kotzé on 'What's important for young people' and Dr Roderick McKay on 'What's important for older people'. | |
| **Mental Health Review Tribunal Recovery Forum**<br>• The Commission supported a one-day forum for the Mental Health Review Tribunal on Recovery principles in action. | **2013** | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | **12 (1)(g)** to advocate for and promote the general health and wellbeing of people who have mental illness and their families and carers. | Principles 11(a) through to 11 (e)(ii). | • One day forum. | • The forum was planned in partnership with the Tribunal, and held on 12 October 2013 and attended by Tribunal members.<br>• The Minister for Mental Health also attended the forum and gave a brief address about the importance in embedding recovery oriented practice within the NSW mental health system.<br>• The objective of the forum was to ensure Tribunal members are resourced to understand, apply and reinforce recovery principles in their everyday work, including being able to foster a sense of hope and recovery in Tribunal hearings and ensure the consumers they see feel valued and heard. | • In seeing patients in every mental health facility across NSW, the Tribunal plays an important role in reinforcing the standard of care expected to be delivered.<br>• The Tribunal is therefore one mechanism through which recovery oriented service delivery can be promoted, tracked and reinforced. |
| **Establishment of National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH)**<br>• NATSILMH is a core group of senior Aboriginal and Torres Strait Islander people working in the areas of social and emotional wellbeing, mental health and suicide prevention.<br>• NATSILMH is financially supported by the NSW, Queensland, WA and National mental health commissions. | **2013** | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | **12 (2)(e)** to take into account the particular views and needs of different sections of the community, including Aboriginal communities, culturally and linguistically diverse communities and regional and remote communities. | Principles 11 (a) through to 11 (e)(ii). | • Event hosting and supporting. | • The Commission supported the establishment of the group in 2013 and continues to support Deputy Commissioner Dr Robyn Shields and Community Advisory Councillor Tom Brideson's membership of the group.<br>• The Commission manages the funding and provides the administrative support of NATSILMH on behalf | • The Commission has supported the work of NATSIMHL in a number of ways, including:<br>- Supported a two day workshop in Sydney to establish the group – over 20 attendees from Aboriginal and Torres Strait Islander organisations across Australia.<br>- Hosted over 20 teleconferences for the group over 3 years. |

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| | | | | | | of all the mental health commissions. | - Facilitated the development of the NATSILMH website and provides ongoing support for the site.<br>- Managed the production and distribution of a key resource – the Gayaa Dhuwi Declaration.<br>- Launched at the 2015 TheMHS Conference. |
| **Trauma Informed Care and Practice Forum and Workshop**<br>• The Commission partnered with MHCC and Blue Knot (formerly ASCA) to host a forum on trauma informed care and practice on 18 November 2013.<br>• The Forum explored how trauma informed approaches can be incorporated into practice across the whole of government and its relevance to *Living Well*.<br>• A report was developed from the forum and submitted as supporting research to *Living Well.* | **2013-2014** | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | **12 (1)(c)** to review and evaluate, and report and advise on, mental health services and other services and programs provided to people who have a mental illness, and other issues affecting people who have a mental illness.<br><br>**12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health. | Principles 11(a) through to 11 (e)(ii) | • *Trauma-informed care and practice: Forum report and evaluation* | • 65 participants attended the workshop from government agencies, health agencies and community managed organisations. | • There was clear acceptance at the forum that trauma informed care and practice is important and necessary in facilitating recovery.<br>• The forum and report outcomes further informed *Living Well.* |
| **Building the Community Sector Forum**<br>• The Commission hosted a one day forum in partnership with the Mental Health Coordinating Council (MHCC) to explore organisational models that optimise business advantages whilst maintaining values-driven and responsive community services.<br>• Participants considered these approaches for NSW Health Grants Management Improvement Plan, Partners in Recovery (PIR) and the National Disability Insurance Scheme (NDIS). | **2014** | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | **12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness. | **11 (d)** the promotion of good mental health and the effective provision of mental health services are the shared responsibility of the government and non-government sectors.<br><br>**11 (e)(i)** an effective mental health system requires a coordinated and integrated approach across all levels of government and the non-government sector, including in the areas of health, housing, employment, education and justice. | • One day forum | • The New Zealand Wise Group Strategic Development Chief Executive Paul Ingle workshopped the operational processes developed by the Wise Group, and provided further insight into the challenges and benefits of this organisational model.<br>• In preparation for the Forum, the Commission funded Platform Trust to develop a paper to share the New Zealand experiences and lessons learnt, which was circulated across the | • This event was the catalyst for the development of Collective Purpose, which has led to financial and organisational efficiencies between WayAhead, BEING and Mental Health Carers NSW.<br>• Through this event, CMO sector leaders were also able to contribute to the development of *Living Well.* |

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| | | | | | | Community Managed Mental Health sector in NSW.<br>• Forum attendees heard about the experiences of three community organisations operating in Australia who have been involved in joint arrangements.<br>• Participants discussed these approaches and models in relation to the NSW Health Grants Management Improvement Plan but also in relation to Commonwealth initiatives such as Partners in Recovery and the NDIS. | |
| **Police Mental Health Intervention Training Evaluation**<br>• The Commission funded an evaluation of the existing four day and one day training programs which delivered Mental Health Intervention Training to 16,000 front-line officers. | **2014** | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | **12 (2)(c)** to take into account issues related to the interaction between people who have mental illness and the criminal justice system. | Principles 11(a) through to 11 (e)(ii). | • Course evaluation. | • The Commission carried out an evaluation of the four day (for selected officers) and new one day (for all officers) training programs for Mental Health Intervention for police officers in NSW. | • In recognition of the powerful impact of the consumer and carer panel that is included within the four-day course, the Commission recommended that videos be created to capture personal stories of people living with mental illness, their journey to recovery, and their experiences in dealing with police. |
| **Police Mental Health Intervention Training Videos**<br>• The Commission partnered with the Schizophrenia Fellowship to develop video materials to be used for a one-day course Mental Health Training. | **2014** | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | **12 (2)(c)** to take into account issues related to the interaction between people who have mental illness and the criminal justice system.<br><br>**12 (2)(d)** to engage and consult with:<br>(i) People who have a mental illness and their families and carers. | Principles 11(a) through to 11 (e)(ii). | • Video material development. | • The Commission partnered with the Schizophrenia Fellowship to develop impactful video material to be used within the one-day course.<br>• The Commission was used to film the material, as a meaningful yet neutral setting for consumers and carers to share their stories. | • Whilst there is no longer a live consumer and carer panel for the one day course due to the obvious limitations of rolling out the one day course to all police officers, the videos are deemed to provide a similar impact.<br>• With the additional one day course now available, 100 percent of officers have now received Mental Health Training, seeing 15,500 officers who had not undertaken the four day program |

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| | | | | | | | trained in mental health and suicide intervention. |
| **Facilitating communication in the criminal justice system (witness intermediaries)**<br>• The Commission co-hosted with the office of the former Attorney General, the Hon. Brad Hazzard MP, a forum that focussed on facilitating communication in the criminal justice system. | **2015** | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | **12 (2)(c)** to take into account issues related to the interaction between people who have a mental illness and the criminal justice system. | **11 (b)** people who have a mental illness and their families and carers should be treated with respect and dignity.<br><br>**11 (d)** the promotion of good mental health and the effective provision of mental health services are the shared responsibility of the government and non-government sectors.<br><br>**11 (e)(i)** an effective mental health system requires a coordinated and integrated approach across all levels of government and the non-government sector, including in the areas of health, housing, employment, education and justice. | • Half day forum. | • The forum featured two guest speakers from the United Kingdom, Joyce Plotnikoff and Richard Woolfson, who discussed their experience with the UK's witness intermediary scheme including its recent evaluation and the establishment of the Advocates Gateway website.<br>• Guests at the forum were drawn from across the Justice Cluster including the Children's Court, Legal Aid NSW, Director of Public Prosecutions, Victims Services, and NSW Department of Justice. | • The forum provided an opportunity for participants from across the Justice sector to gain practical advice about working with vulnerable witnesses and defendants. |
| **'Open Dialogue', Dr Christopher Gordon and Brenda Miele Soares**<br>• A public information session and special briefing was delivered on 'Open Dialogue', an innovative, network-based approach to assisting people who experience severe psychiatric crises and conditions based on a successful model from Finland. | **2015** | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | **12 (1)(g)** to advocate for and promote the general health and wellbeing of people who have mental illness and their families and carers.<br><br>**12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness. | Principles 11(a) through to 11 (e)(ii). | • Special briefing<br>• Public information session | • Two information sessions:<br>- Special briefing for NSW Health Mental Health Leaders<br>- Public information session<br>• The information sessions featured visiting international guests Dr Christopher Gordon, Senior Vice President, Clinical Services Medical Director and Brenda Miele Soares, Director of Psychiatric Rehabilitation from Advocates Hospital in Massachusetts, USA. | • The outcomes included:<br>- 40 NSW Health mental health staff from across NSW.<br>- 75 attendees at the public session.<br>- 3923 YouTube views of the video of 'Open Dialogue' presentation: New approaches to mental health services.<br>• An ongoing Open Dialogue group is now hosted by Niels Buss, Professor of Mental Health Nursing at St. Vincent's Hospital. |

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| **'Wraparound Milwaukee', Bruce Kamradt**<br>• Visiting US Mental Health Director, Bruce Kamradt, founder of "Wraparound Milwaukee" service, presented to local organisations on how service provides care for children with serious emotional, behavioural, and mental health needs and their families.<br>• The service uses a 'wraparound' philosophy which focuses on strength-based, individualised care, focusing instead on services for children and their families in the community and the child's home. | **2015** | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | **12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health. | Principles 11(a) through to 11 (e)(ii). | • Presentation | • Organisations charged with caring for vulnerable children in NSW were given the opportunity to hear about a unique model of care called Wraparound Milwaukee when the Commission hosted the model's founder.<br>• The presentation was sent to all attendees and those expressing interest in the model. | • This philosophy aligns with the principles underpinning *Living Well* and highlighted a different perspective on community approaches to mental health services, to organisations including the Department of Family and Community Services, the Ministry of Health, NSW Institute of Psychiatrists, Juvenile Justice, Headspace, Richmond RPA and more.<br>• 30 employees from local government and non-government organisations attended. |
| **Wellbeing Collaborative**<br>• The NSW Wellbeing Collaborative was formally established in June 2015 to support wellbeing initiatives among organisations, share knowledge and promote innovative and successful activities. | **2015-2016** | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers. | **11 (d)** the promotion of good mental health and the effective provision of mental health services are the shared responsibility of the government and non-government sectors.<br><br>**11 (e)(i)** an effective mental health system requires a coordinated and integrated approach across all levels of government and the non-government sector, including in the areas of health, housing, employment, education and justice.<br><br>. | • *Wellbeing Collaborative – Wellbeing is Everybody's Business- discussions paper*<br>• Website<br>• MWIA Toolkit | • The Collaborative's role is to:<br>- Promote awareness across government and the community that wellbeing is 'everybody's business'.<br>- Provide leadership across government and the community for the promotion of wellbeing.<br>• The Mental Wellbeing Impact Assessment (MWIA) was piloted across three sites in NSW in 2015 and in 2016 a number of agencies partnered in training their representatives in the MWIA methodology.<br>• Work in 2015 – 2016 focused on bringing together current knowledge and evidence related to the case for wellbeing, guiding principles for its promotion, and advice on measurement and evaluation. | • This work brought together representatives from government and community organisations and provided a backbone of support to the ongoing collaboration between these organisations.<br>• The initiative also facilitated collaboration between government and community organisations. |

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| | | | | | | • The delivery mechanisms for this information have been tested through the application of design thinking through a partnership with the UTS Design Innovation Research Centre. | |
| **Health Justice Partnerships (HJPs)**<br>• The Commission co-chairs the Health Justice Partnerships Community of Practice (CoP) in NSW.<br>• Health justice partnerships are a model of collaboration between legal and health sectors to provide better health and wellbeing outcomes for disadvantaged communities. | **2015-Ongoing** | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers.<br><br>**12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing stigma associated with mental illness and the discrimination against people who have a mental illness. | **11 (b)** people who have a mental illness and their families and carers should be treated with respect and dignity.<br><br>**11 (d)** the promotion of good mental health and the effective provision of mental health services are the shared responsibility of the government and non-government sectors.<br><br>**11 (e)(i)** an effective mental health system requires a coordinated and integrated approach across all levels of government and the non-government sector, including in the areas of health, housing, employment, education and justice. | • *Health Justice Partnerships in New South Wales: Position Paper*<br>• Workshop | • The CoP established a steering committee which has representation from Local Health Districts, Legal Aid, the Department of Family and Community Services, private law firms and community legal centres and aims to champion health justice partnerships and identify and develop opportunities for cooperation.<br>• As neither a health nor legal service, the Commission is able to provide a 'neutral' but authoritative perspective in this regard.<br>• In 2016 the Commission developed a position paper that explains in depth what an HJP is, how they apply in NSW and the benefits they deliver for clients and service providers.<br>• In 2017 the Commission partnered with Legal Aid NSW to host a forum for lawyers and health professionals on how they can achieve a person-centred partnership. | • Legal and health practitioners are embracing the concept of consumer participation and engagement to improve the work in both practice areas.<br>• Around 200 organisations participate in the NSW HJP CoP. |

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| **'Slow Psychiatry', Dr Sandra Steingard**<br>• A special lecture was given by visiting international psychiatrist Dr Sandra Steingard, a Medical Director at Howard Center in Vermont, a community mental health organisation where she has worked for the past 17 years. | **2016** | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | **12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness. | Principles 11 (a) through to 11 (e)(ii). | • Free public lecture | • A public lecture including an hour of Q&A was delivered by Dr Steingard focusing on 'slow psychiatry', which Dr Steingard describes as the integration of 'need-adapted' models of mental health care such as Open Dialogue with the use of psychoactive agents in a "cautious and humble way". | • The outcomes included:<br>- Over 100 attendees at the public lecture.<br>- 755 views of her presentation on SlideShare.<br>- 536 YouTube views of the video of 'Slow psychiatry': a special briefing by Dr Sandra Steingard. |
| **Promoting Mentally Healthy Cities, Dr Arthur Evans**<br>• The innovator, clinical psychologist and commissioner of Philadelphia's Department of Behavioural Health and Intellectual disability Services (DBHIDS), Dr. Arthur C. Evans Jr has measurably improved the mental health of communities and lowered treatment costs in his native city of Philadelphia in the US by taking solutions to the people rather than waiting for people to come for treatment. | **2016** | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | **12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing stigma associated with mental illness and the discrimination against people who have a mental illness. | **11 (b)** people who have a mental illness and their families and carers should be treated with respect and dignity.<br><br>**11 (e)(i)** an effective mental health system requires a coordinated and integrated approach across all levels of government and the non-government sector, including in the areas of health, housing, employment, education and justice. | • Guest Lecture | • Dr. Arthur C. Evans Jr addressed an audience of Sydney mental health leaders on how they can empower communities to improve mental wellness. | • The outcomes included:<br>- The Video of the talk was viewed more than 250 times.<br>- 200 mental health and urban design leaders attended this public lecture. |
| **Trauma Project on Australia News Media Depictions of Child Sexual Abuse**<br>• This work examines the literature about the safety of media and other public conversations concerning child sexual abuse and how this potentially impacts on individuals and the wider community. | **2016-Ongoing** | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | **12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing stigma associated with mental illness and the discrimination against people who have a mental illness. | **11 (b)** people who have a mental illness and their families and carers should be treated with respect and dignity.<br><br>**11 (e)(ii)** an effective mental health system requires communication and collaboration between people who have a mental illness and their families and carers, providers of mental health services and the whole of community. | • Literature review. | • Blue Knot Foundation were engaged to conduct a literature review about the safety of media and other public conversations concerning child sexual abuse. | • This work makes recommendations about further potential projects, including the development of media guidelines. |
| **International Initiative in Mental Health Leadership (IIMHL) Exchange** C<br>• International leaders in mental health attended the 2017 International Initiative in Mental Health Leadership | **2017** | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | **12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers. | Principles 11(a) through to 11 (e)(ii) | • Presentations<br>• Short videos<br>• Match Reports<br>• Articles | • Over 400 leaders in mental health from around the globe gathered in Australia in early March 2017 for five days of information exchange on how to | • The Exchange brings mental health leaders together to solve problems, to share innovations, and to make connections with those |

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| (IIMHL) Exchange, co-hosted by the NSW Mental Health Commission and NSW Ministry of Health. | | | | | | make mental health services better.<br>• The Exchange is held every 16 months. | working on the other side of the world. |
| **Community Mental Health Drug and Alcohol Research Network (CMHDARN)**<br>• The Commission funds CMHDARN, a partnership project between MHCC, the Network of Alcohol and other Drugs Agencies (NADA) and the Commission.<br>• CMHDARN was established in 2010 to provide opportunities to better integrate community-managed drug and alcohol and mental health responses, and build intersections between the two sectors to support strategic, long-term relationships with research institutions and academics. | **2013-2017** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (2)(b)** to take into account co-morbid issues associated with mental illness, such as drug and alcohol use and disability. | **11 (d)** the promotion of good mental health and the effective provision of mental health services are the shared responsibility of the government and non-government sectors,<br><br>**11 (e)(i)** an effective mental health system requires a coordinated and integrated approach across all levels of government and the non-government sector, including in the areas of health, housing, employment, education and justice.<br><br>**11 (e)(ii)** an effective mental health system requires communication and collaboration between people who have mental illness and their families and carers, providers of mental health services, and the whole community. | • Events<br>• Online resources<br>• Launch of a new Research Seeding Grant Program for 2017 | • In order to build the research capacity of the mental health and alcohol and other drugs sectors, the network shares information and engages with members via its website, workshops, forums, reflective practice, webinars/webcasts and other activities. | • The Network provides opportunities to better integrate the community-managed drug and alcohol and mental health sectors, and build intersections between the two sectors to support strategic, long-term relationships with research institutions and academics. |

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| **Improving Mental Health and Wellbeing of People with Intellectual Disability** C<br>• The Commission partnered in a project led by the University of New South Wales (UNSW) and funded by the National Health and Medical Research Council (NHMRC) (funded in kind by the Commission), which focused on improving the mental health outcomes of people with intellectual disability. | **2013-2017** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers.<br><br>**12 (2)(b)** to take into account co-morbid issues associated with mental illness, such as drug and alcohol use and disability. | **11 (a)** people who have a mental illness, wherever they live, should have access to the best possible mental health care and support.<br><br>**11 (b)** people who have a mental illness and their families and carers should be treated with respect and dignity.<br><br>**11 (c)** the primary objective of the mental health system should be to support people who have a mental illness to participate fully in community life and lead meaningful lives.<br><br>**11 (e)(ii)** an effective mental health system requires communication and collaboration between people who have mental illness and their families and carers, providers of mental health services, and the whole community. | • Data linkage<br>• Policy review | • The project included data linkage to better understand current access to mental health services by people with an intellectual disability, and a review of current policy at a national and state level.<br>• The Commission provided in-kind and financial support to an NHMRC grant to 3DN at UNSW. | • TBD |
| **Mental Health and Homelessness Report**<br>• The report looks at key issues in the area of mental health and homelessness and makes recommendations for possible solutions and improvement. | **2013** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers. | Principles 11 (a) through to 11 (e)(ii). | • *Mental Health and Homelessness: Final Report*<br>• Stakeholder forum | • The Commission engaged the Australian Housing and Urban Research Institute (AHURI) to prepare a research synthesis report outlining evidence on addressing homelessness of people with mental illness from published research and evaluations.<br>• In conjunction with the report, the Commission held a stakeholder forum on 13 May 2013 with more than 70 representatives from Government, community-managed organisations, subject | • The research and the recommendations, challenges and opportunities identified by forum participants were provided to the NSW Premier's Council on Homelessness to inform its consideration of mental health and homelessness.<br>• The forum outcomes also helped shape the Commission's development of *Living Well.* |

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| | | | | | | matter experts and academics. | |
| **Communities matter** C<br>• Communities Matter a joint project of the Commission and Suicide Prevention Australia, and provides a toolkit to support small towns and local communities to turn conversations and interest in suicide prevention into activities that reflect local need.<br>• The toolkit outlines, in plain English, evidence-informed suicide prevention strategies to support communities to undertake suicide prevention activities and combat stigma.<br>• As part of the toolkit, the 'Supporting CALD communities to talk about suicide' resource was funded by the Commission and developed in partnership with the Transcultural Mental Health Centre NSW. | **2013-Ongoing** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers.<br><br>**12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing stigma associated with mental illness and the discrimination against people who have a mental illness.<br><br>**12 (2)(e)** to take into account the particular views and needs of different sections of the community, including Aboriginal communities, culturally and linguistically diverse communities and regional and remote communities. | Principles 11 (a) through to 11 (e)(ii). | • Online toolkit | • In October 2013, the former NSW Minister for Mental Health launched the toolkit in Dubbo, and it was subsequently trialled in the towns of Walgett and Hay.<br>• The former Minister for Mental Health and the Commissioner sent a joint letter to all Mayors in NSW asking them to promote Communities Matter in their local government areas.<br>• The evaluation recommended that the toolkit's wording be simpler and available on an easy to navigate website with clear practical tips about how to establish a sustainable suicide prevention community action group.<br>• Subsequently, the Commission and Suicide Prevention Australia developed an online version of the toolkit in 2015. | • There has been a steady stream of new visitors to the Communities Matter website every month since it went live, to date there has been 971 visitors to the website.<br>• An independent evaluation showed that *Communities Matter* was well-received by the trial communities. |
| **Conversations matter**<br>• An online guide to help individuals, professionals and communities have safe, supportive and productive conversations about suicide.<br>• Since its inception in 2013, the resource has grown to include materials tailored for professionals working with Aboriginal CALD communities. | **2013-Ongoing** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers.<br><br>**12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness. | Principles 11 (a) through to 11 (e)(ii). | • Online resources | • Conversations Matter was developed under a project originally called "Community Guidelines for Discussing Suicide", funded as part of the NSW Suicide Prevention Strategy 2010-2015.<br>• The Hunter Institute of Mental Health (HIMH) was contracted by the NSW Ministry of Health to work in consultation | • Ongoing development and publication of resources (brochures and podcasts) tailored to vulnerable communities. |

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| | | | **12 (2)(e)** to take into account the particular views and needs of different sections of the community, including Aboriginal communities, culturally and linguistically diverse communities and regional and remote communities. | | | with a state-wide steering committee to develop resources to support community conversations about suicide. | |
| **Promotion, prevention and early intervention evidence guide**<br>The Commission engaged the Hunter Institute for Mental Health in 2014 to produce *Promotion, Prevention and Early Intervention: an Evidence Guide* that examines the evidence base for prevention and early intervention of mental ill-health, including gaps in the evidence. | **2014** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health. | **11 (c)** the primary objective of the mental health system should be to support people who have a mental illness to participate fully in community life and lead meaningful lives.<br><br>**11 (d)** the promotion of good mental health and the effective provision of mental health services are the shared responsibility of the government and non-government sectors. | • *Promotion, Prevention and Early Intervention: an Evidence Guide* | • The Commission engaged the support of the Hunter Institute for Mental Health to produce this report. | • The Commission granted permission for the Hunter Institute for Mental Health to publish and disseminate this work. |
| **Supporting Your Friends Research Project – *Support in Tough Times***<br>• The Commission partnered with the NSW Commission for Children and Young People (CCYP) to research the impact of schools on whether and how young people involve adults when their friends have a mental health problem. | **2014** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **S12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing stigma associated with mental illness and the discrimination against people who have a mental illness. | Principles 11 (a) through to 11 (e)(ii). | • *Support in tough times: Encouraging young people to seek help for their friends* | • The research was undertaken by CCYP with financial support from the Commission. The study used a combination of online survey tools for students and principals, as well as student focus groups. 3,241 students in Years 9 and 10 contributed, from 121 schools across the public, Catholic and independent school sectors. | • The findings in the report improved understanding of the effects of the school environment, teacher-student relationships, parent-school relationships, and mental health education on students referring mental health issues to adults – with implications for school-based mental health promotion programs. |

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| **NSW Electroconvulsive Therapy (ECT) Research Network**<br>• The Commission funded the UNSW for the CARE (Clinical Alliance and Research in ECT) project which aims to improve clinical ECT services by recommending a set of ECT-appropriate outcome measures, and providing training in their use. | **2014 - 2015** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **S12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing stigma associated with mental illness and the discrimination against people who have a mental illness. | Principles 11 (a) through to 11 (e)(ii). | • A network of hospitals that conduct electroconvulsive therapy (ECT), to contribute to a world-first clinical database. | • The project was developed by leading psychiatrists with both clinical and research expertise in ECT, after wide consultation with experts across Australia.<br>• The work contributes to a world-first clinical database with potential to identify the safest and most effective approaches to ECT, and to train clinicians in their use. | • 32 Australian hospitals participate in the network, including 17 in NSW, and 75 NSW clinicians have been trained in cognitive testing for ECT consumers.<br>• Benchmarking confirmed that ECT is effective and results in a substantial improvement in quality of life, but also that there is considerable clinical variation in ECT practice and outcomes. |
| **Review of the NSW Population Health Survey**<br>• During 2014/15, the Commission engaged the Centre for Epidemiology and Evidence and the NSW Ministry of Health (InforMH, Mental Health Branch) in a review of the NSW Population Health Survey, with a view to a review of existing mental health questions, the addition of new mental health and wellbeing questions, as well as analysis of existing mental health data. | **2014 - 2015** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers. | **11 (c)** the primary objective of the mental health system should be to support people who have a mental illness to participate fully in community life and lead meaningful lives. | • Updated mental health questions in the NSW Population Health Survey. | • In 2015 the Commission undertook additional analysis of the mental health data and included the findings in *One Year On.* | • This initiative catalysed the review of the mental health questions in the NSW Population Health Survey and the addition of new mental health questions.<br>• In 2016, InforMH confirmed the inclusion of new mental health and wellbeing questions in the Survey as per discussions with the Commission. |
| **Measuring Consumer Experiences of Care – the *Your Experiences of Service*s (YES) information technology pilot**<br>• During 2014/15 the Commission worked in partnership with the NSW Ministry of Health (InforMH), BEING and the MHCC to enhance the collection of consumers' experiences of care via the YES measure, through the development of a pilot project that would examine how information technology could best support YES data collection, analysis and use. | **2014 - 2015** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (2)(d)** to engage and consult with:<br>(i) People who have a mental illness and their families and carers.<br>(ii) The government and non- government sectors.<br>(iii) The whole community. | **11 (a)** people who have a mental illness, wherever they live, should have access to the best possible mental health care and support.<br><br>**11 (b)** people who have a mental illness and their families and carers should be treated with respect and dignity.<br><br>**11 (c)** the primary objective of the mental health system should be to support people who have a mental illness to participate fully in community life and lead meaningful lives. | • Information technology technical specifications proposal.<br>• Evaluation proposal. | • In 2015 the Commission drafted an information technology technical specifications proposal, as well as an evaluation proposal, with a view to funding, supporting and evaluating the pilot project.<br>• In 2015 the NSW Ministry of Health (InforMH) confirmed that due to changes in its resources, it had the capacity to lead and undertake the pilot and its evaluation within its own internal funds. | The Commission's involvement in this initiative was the catalyst for further efforts of NSW Ministry of Health in this area. |

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| | | | | **11 (e)(ii)** an effective mental health system requires communication and collaboration between people who have mental illness and their families and carers, providers of mental health services, and the whole community. | | | |
| **Consumer Led Research Network (CLRN)**<br>• The Commission supported the establishment of the Consumer Led Research Network (CLRN), to promote, support and undertake consumer led research activities in NSW.<br>• The Commission supported the Network to hold its first a public forum, on 'Enabling consumer led and co-production research in a world that's not used to it.' | **2014-Ongoing** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (2)(d)** to engage and consult with:<br>(i) People who have a mental illness and their families and carers.<br>(ii) The government and non- government sectors.<br>(iii) The whole community. | **11 (b)** people who have a mental illness and their families and carers should be treated with respect and dignity.<br><br>**11 (e)(ii)** an effective mental health system requires communication and collaboration between people who have mental illness and their families and carers, providers of mental health services, and the whole community. | • Public Forum<br>• Ongoing secretariat support. | • Members of the CLRN came together for their first meeting on 29 October 2014, establishing an environment for the discussion of consumer led research activities in NSW.<br>• The Network is independent of the Commission but supported by the Commission with secretariat support for its quarterly meetings. | • The forum identified a number of priorities for consumer researchers and for the broader research community.<br>• The forum affirmed the principle that consumers need to be centrally involved at all stages of research beginning with priority setting and research design.<br>• The most prevalent indicator of the network's success has been the many approaches it has received from mental health services to provide advice on and contribute to research projects in NSW. |
| **iBobbly** C<br><br>• The Commission contracted the Black Dog Institute to extend and improve the content of the iBobbly smartphone app to reach young Aboriginal people who are at risk of suicide, and delivers treatment-based therapy in a culturally relevant way.<br>• The name of the app is derived from a Kimberley greeting. | **2015** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health. | **11 (a)** people who have a mental illness, wherever they live, should have access to the best possible mental health care and support.<br><br>**11 (c)** the primary objective of the mental health system should be to support people who have a mental illness to participate fully in community life and lead meaningful lives.<br><br>**11 (e)(ii)** an effective mental health system requires communication and collaboration between people who have mental illness and their families and carers, providers of mental | • *The extension of iBobbly: an app to reduce suicidality among young Aboriginal and Torres Strait Islander people* | • Based on the feedback from the pilot and other consultations across Australia, a new version is under development.<br>• Several Indigenous organisations around Australia have been instrumental in providing input for this version of the app. | • A pilot version of iBobbly was tested in the Kimberley with favourable outcomes.<br>• The app's future success will be measured by how relevant and engaging the app is to a wider group of users, its uptake and evaluation in regions outside Broome (where it was originally piloted), and the success of its national trial, currently underway. |

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| | | | | health services, and the whole community. | | | |
| **ReachOut.com – Pathways to Mental Health Care in Western NSW** C<br>• The Pathways to Mental Healthcare in Western New South Wales pilot project was a six-week pilot of a new online self-assessment tool that linked young people to three levels of mental health support through a stepped-care approach. | **2015** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health. | **11 (a)** people who have a mental illness, wherever they live, should have access to the best possible mental health care and support.<br><br>**11 (c)** the primary objective of the mental health system should be to support people who have a mental illness to participate fully in community life and lead meaningful lives.<br><br>**11 (e)(i)** an effective mental health system requires a coordinated and integrated approach across all levels of government and the non-government sector, including in the areas of health, housing, employment, education and justice. | • Online tool | • The Commission partnered with ReachOut.com, to deliver one of the first pilot projects in Australia to integrate online and offline mental health services.<br>• The tool, designed in partnership with young people from Western NSW, included detailed local service mapping and provided clear actionable steps to follow allowing young people to recognise and understand the issues they are experiencing and find the most suitable support, including online discussion forums, local services offering face-to-face support or phone support, that can be accessed immediately. | • The tool assesses a young persons' needs with respect to 13 mental health issues and, in response, provides personalised and relevant service recommendations to online and offline supports and services. |
| **LHD Seed grants**<br>• In March 2015, the Commission invited NSW LHDs and Specialty Networks to submit Expressions of Interest for funding for projects that effectively plan and seed activities for the implementation of *Living Well.* | **2015** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers.<br><br>**12 (2)(e)** to take into account the particular views and needs of different sections of the community, including Aboriginal communities, | Principles 11 (a) through to 11 (e)(ii). | • Grants | • The Commission invited NSW Local Health Districts (LHDs) and specialty networks to submit Expressions of Interest for funding for projects. | • 14 projects were funded and can be viewed here: Project Funding to Support Reform. |

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| | | | culturally and linguistically diverse communities and regional and remote communities. | | | | |
| **National Surveys of Mental Health Literacy and Stigma- Analysis of NSW results**<br>• The Commission obtained NSW results from the National Survey to better understand the experience of people in NSW regarding stigma and discrimination around mental health. | **2015** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers.<br><br>**12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness. | **11 (b)** people who have a mental illness and their families and carers should be treated with respect and dignity.<br><br>**11 (d)** the promotion of good mental health and the effective provision of mental health services are the shared responsibility of the government and non-government sectors. | • *National Surveys of Mental Health Literacy, Stigma and Discrimination – NSW findings*<br>• *Summary of University of Melbourne report on NSW findings for National Surveys* | • In 2015 the Commission contracted the University of Melbourne to deliver a report on NSW data from the National Surveys. | • The studies were completed in 2015 and the findings were reported in *One Year On.* |
| **Synergy Online Ecosystem Trial** C<br>• The Commission supported the trial of NSW Synergy Online Ecosystem, a world first created by the Young and Well Cooperative Research Centre and the Brain and Mind Centre at the University of Sydney, which integrates apps and tools that assist young people.<br>• Young people in NSW aged 16 to 25 who live in Western Sydney, the Central Coast and Far West NSW were invited to take part. | **2015-2016** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health. | **11 (a)** people who have a mental illness, wherever they live, should have access to the best possible mental health care and support.<br><br>**11 (c)** the primary objective of the mental health system should be to support people who have a mental illness to participate fully in community life and lead meaningful lives.<br><br>**11 (e)(i)** an effective mental health system requires a coordinated and integrated approach across all levels of government and the non-government sector, including in the areas of health, housing, employment, education and justice. | • Online health and wellbeing system | • The Commission partnered with the Young and Well CRC and Brain and Mind Centre.<br>• A key feature of the online system is the interoperability of the three integrated services – Happiness Central, Mental Health eClinic and ReachOut NextStep, which guides the young person through the ecosystem based on their specific need. | • A key commitment of the policy to strengthen mental health care in Australia is a $30 million package to extend regional trials of Project Synergy over the next three years. |
| **Far West NSW Atlas**<br>• Funded by the Commission, and delivered in partnership with the Mental Health Policy Unit at the University of Sydney, this resource aims to help services, | **2015-2016** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (2)(e)** to take into account the particular views and needs of different sections of the community, including Aboriginal communities, culturally and linguistically | **11 (a)** people who have a mental illness, wherever they live, should have access to the best possible mental health care and support. | • *Integrated Mental Health Atlas of Far West NSW* | • The Commission engaged Professor Louis Salvador-Carulla, Head of the Mental Health Policy Unit at the University of Sydney, to | • The exercise resulted in public resource based on international classifications and standards. |

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| planners and funding bodies to identify existing capacity and identify service gaps in mental health across the Far West district.<br>• The project was part of an international effort which for the first time provides a consistent way to classify and geo-locate the range of mental health services on offer across health, social care, education, employment and housing. | | | diverse communities and regional and remote communities. | **11 (d)** the promotion of good mental health and the effective provision of mental health services are the shared responsibility of the government and non-government sectors. | | employ his unique service mapping technique. | • The Atlas was immediately used by Far West NSW LHD and PHN.<br>• The research contributes to a pool of other Mental Health Atlases developed using the same methodology. |
| **Living Well in Later Life**<br>• This document details the particular needs and circumstances of older people and their mental health needs as they age<br>• In 2015 the Commission began working with the Faculty of Psychiatry of Old Age within the Royal Australian and New Zealand College of Psychiatrists, and with other stakeholder groups, to explore issues particular to the mental health of older people, and any implications they have for the provision of mental health and related social services in NSW. | **2015-2017** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers.<br><br>**12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness. | Principles 11 (a) through to 11 (e)(ii). | • *Living Well in Later Life: The Case for Change*<br>• *Living Well in Later Life: A Statement of Principles* | • The Commission established an expert Advisory Group to guide its work in this area.<br>• Consultations were undertaken during 2015/16 with mental health and aged care experts, as well as with older people with lived experience of mental health problems, to guide the planning and delivery of services for people with mental health issues in older age.<br>• The Case for Change and Statement of Principles documents were drafted to reflect the available evidence and feedback received.<br>• A final round of consultations was undertaken in early 2017 with the sector on these documents. | • The documents were launched on 25 July 2017. |
| **Justice data linkage project**<br>• The Commission sought to look at the relationship between psychosis and offending in NSW.<br>• People with mental illnesses are over-represented in the criminal justice system and this study will add significantly to our | **2015-2017** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers, | **(e)(i)** an effective mental health system requires a coordinated and integrated approach across all levels of government and the non-government sector, including in the areas of health, housing, employment, education and justice. | • N/A | • The Commission worked with researchers from the Kirby Institute at UNSW to link major data sets from NSW Health, NSW Bureau of Crime Statistics and Research, and Corrective Services. | • Results from this project will contribute to one of our primary indicators for reform which is to reduce the proportion of people in the prison population who have mental illness. |

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| understanding of this population and their needs. | | | **12 (2)(c)** to take into account issues related to the interaction between people who have mental illness and the criminal justice system. | | | | • The launch of this work was on 27 July 2017 in Parliament House. |
| **Peer work hub** C<br>• The Commission hosts regular forums on peer workforce development.<br>• The Peer Work Hub is an online resource for employers and provides evidence and advice for employers on how and why they should develop a mental health peer workforce within their organisation.<br>• The Peer Work Hub was launched in May 2016. | **2015-Ongoing** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (2)(d)** to engage and consult with:<br>(i) People who have a mental illness and their families and carers.<br>(ii) The government and non- government sectors.<br>(iii) The whole community. | Principles 11 (a) through to 11 (e)(ii). | • Forum<br>• Synthesis Paper<br>• Online resource | • Over 100 people gathered to further explore the benefits of, and challenges to, this reform at the Peer Work Forum hosted at Australian Technology Park, Sydney, on Monday 23 March 2015 by the Commission.<br>• The forum, targeted decision-makers, recruiters and managers of organisations seeking to establish or grow their peer workforce.<br>• Keynote speaker Larry Davidson, Professor of Psychiatry and Director, Yale Program for Recovery and Community Health, provided an international perspective.<br>• Other speakers and panel members represented agencies and organisations including Mind Australia; MHCC; CAN Mental Health; NSW Consumer Workers Committee; Richmond PRA; Justice Health; and Family and Community Services. | • The Commission's advocacy for peer work through *Living Well,* the Peer Work Forum and the Peer Work Hub is a driver of the work of the Ministry of Health in strengthening the peer workforce since the adoption of *Living Well*.<br>• The Ministry of Health appointed a state-wide coordinator for peer work and the inclusion in funding agreements with LHDs and KPIs related to peer workers. |
| **Suicide Prevention Workstream**<br>• A workstream aimed at developing a systems approach to suicide prevention across NSW.<br>• The systems approach recognises that multiple strategies implemented at the | **2015-Ongoing** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12(1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers. | Principles 11 (a) through to 11 (e)(ii). | • *Proposed Suicided Prevention Framework for NSW (August 2015)*<br>• *Implementation plan for the systems approach to suicide prevention in NSW summary paper (October 2015)* | • Following the expiry of the *NSW Suicide Prevention Strategy 2010-2015*, the Commission funded the National Health and Medical Research Council's Centre of Research Excellence in | • The framework was adopted in NSW PHNs and more broadly by the Ministry of Health which, in May 2017, dispersed $8M to non-government agencies whose proposed suicide prevention activities are aligned to |

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| same time are likely to generate bigger effects than just the sum of its parts. | | | | | • NSW Suicide Prevention Advisory Group (2016). | Suicide Prevention to develop, with the Black Dog Institute, an ongoing framework for suicide prevention. The resulting *Proposed Suicide Prevention Framework for NSW* was launched at a National Suicide Prevention Summit at Parliament House in Canberra on 10 August 2015<br>• In 2016 the Commission established the NSW Suicide Prevention Advisory Group, to advise the Commissioner on issues relating to suicide prevention and to improve the planning, monitoring and co-ordination of suicide prevention activities in NSW. | the Framework's strategies.<br>• Following the adoption of the Framework at the National Suicide Prevention Summit at federal Parliament in August 2015, the Commission's work influenced the Commonwealth government to fund 12 suicide prevention trial sites nationwide in 2016, providing the PHNs with a guide to suicide prevention commissioning based on the strategies of the NSW systems approach trial.<br>• Leaders from industry, government and the non-government sectors have an opportunity to share their research and activities on a regular basis through the NSW Suicide Prevention Advisory Group.<br>• Based on this foundational work, in December 2015 the Black Dog Institute secured $14.7 million from the Ramsay Foundation, to support a NSW trial of the systems approach, developed the *Implementation plan for the systems approach to suicide prevention in NSW summary paper,* resulting in *Lifespan*- an evidence based systems approach to suicide prevention. |
| **Butterfly Insights in Recovery Report**<br>• This project sought and collated advice from more than 100 Australians who have experienced an eating disorder on what aided their recovery. | **2015-2016** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(g)** to advocate for and promote the general health | **11 (b)** people who have a mental illness and their families and carers should be treated with respect and dignity. | • *Insights in Recovery: A consumer-informed guide for health practitioners working with people with eating disorders* | • Researchers used online surveys and focus groups to gather feedback from people with lived experience of eating disorders about | • This guide provides guidance for health professionals of all kinds on how to adopt a person-centred, recovery-orientated approach to working with people with |

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| • The resource was developed by the Butterfly Foundation with funding from the Commission. | | | and well-being of people who have a mental illness and their families and carers.<br><br>**12 (2)(d)** to engage and consult with:<br>(i) People who have a mental illness and their families and carers.<br>(ii) The government and non- government sectors.<br>(iii) The whole community. | **11 (c)** the primary objective of the mental health system should be to support people who have a mental illness to participate fully in community life and lead meaningful lives.<br><br>**11 (e)(i)** an effective mental health system requires a coordinated and integrated approach across all levels of government and the non-government sector, including in the areas of health, housing, employment, education and justice.<br><br>**11 (e)(ii)** an effective mental health system requires communication and collaboration between people who have mental illness and their families and carers, providers of mental health services, and the whole community. | | what helped and hindered their recovery.<br>• The findings were translated into a guide that aims to help health professionals of all kinds adopt a person-centred, recovery-oriented approach when working with people with anorexia, bulimia or other eating disorders. | anorexia, bulimia and other eating disorders.<br>• The resource fills a gap by providing a companion piece to clinical guidelines on eating disorders and a specific application of recovery oriented guidelines to an often misunderstood set of illnesses. |
| **Physical health and mental wellbeing evidence guide**<br>• The Commission developed the *Physical Health and Mental Wellbeing: an Evidence Guide* which outlines current evidence and the importance of addressing physical health and wellbeing in people living with mental illness.<br>• The guide also identifies gaps in the evidence base and areas for future work and research relating to physical health and wellbeing in people living with mental illness. | **2016** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health | **11 (c)** the primary objective of the mental health system should be to support people who have a mental illness to participate fully in community life and lead meaningful lives. | • *Physical Health and Mental Wellbeing: an Evidence Guide* | • The Commission engaged the UNSW and experts from Sydney South East Local Health District's Mental Health Service to contribute to the research. | • In concert with this and related activity, the Commission also reached out to the National Mental Health Commission and an expert reference group was established to guide the development of a consensus statement on physical health, due to be released in mid-2017. |

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| **Effectiveness of Services Led and Run by Consumers Review**<br>• This review paper illustrates the evidence to support consumer led and run services, and offers conclusions and policy and practice implications. | **2016** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | **11 (d)** the promotion of good mental health and the effective provision of mental health services are the shared responsibility of the government and non-government sectors.<br><br>**11 (e)(ii)** an effective mental health system requires communication and collaboration between people who have mental illness and their families and carers, providers of mental health services, and the whole community. | • *The effectiveness of services led or run by consumers in mental health* | • Beginning in April 2015, the Sax Institute was engaged to undertake a literature review on consumer-run services identifying the best quality evidence for 'what is known about what works' for mental health service models that include consumer run/led services.<br>• The Commission worked closely with BEING to develop the research proposal and the research team included researchers with lived experience of mental illness.<br>• A total of 33 peer reviewed papers and associated literature were reviewed in the report. | • The review detailed evidence to support consumer led and run services, and offered conclusions, and policy and practice implications.<br>• The information in the review also provided some suggestions for next steps in building and growing services led and run by consumers in NSW. |
| **Mental Health and Wellbeing Strategy for NSW First Responder Organisations**<br>• The Commission developed a mental health and wellbeing strategy for NSW first responder agencies.<br>• This is the first time in Australia's history that first responder agencies have collaborated to develop a shared mental health and wellbeing strategy. | **2016** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers.<br><br>**12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing stigma associated with mental illness and the discrimination against people who have a mental illness.<br><br>**12 (2)(d)** to engage and consult with:<br>(i) People who have a mental illness and their families and carers.<br>(ii) The government and non- government sectors. | **11 (b)** people who have a mental illness and their families and carers should be treated with respect and dignity.<br><br>**11 (d)** the promotion of good mental health and the effective provision of mental health services are the shared responsibility of the government and non-government sectors.<br><br>**11 (e)(i)** an effective mental health system requires a coordinated and integrated approach across all levels of government and the non-government sector, including in the areas of health, housing, employment, education and justice. | • *Mental health and wellbeing strategy for first responder organisations in NSW*<br>• Key print and video supporting resources. | • The Commission brought the agencies together in a neutral setting and facilitated the strategy's development, and the Black Dog Institute, provided the evidence base to support the strategy direction.<br>• UNSW researcher and workplace mental health expert Associate Professor Sam Harvey, who is based at the Black Dog Institute, was the strategy's lead author. | • Consensus between agencies has formed the basis for ongoing collaboration and development.<br>• Funding was negotiated for ongoing research by Black Dog Institute<br>• Commission videos are used routinely by first responder agencies.<br>• More than 4000 views of long form and short through the Commission You Tube channel. |

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| | | | (iii) The whole community. | | | | |
| **Coronial data analysis**<br>• Understand the circumstances of an individual's death where the person has had contact with the mental health system, or where mental illness has in any way contributed to their death. | **2016-2017** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers. | **11 (a)** people who have a mental illness, wherever they live, should have access to the best possible mental health care and support.<br>**11 (e)(i)** an effective mental health system requires a coordinated and integrated approach across all levels of government and the non-government sector, including in the areas of health, housing, employment, education and justice. | • N/A | • The Commission engaged the University of Sydney to analyse the findings of the findings of the NSW Coroner's Court. | • These findings shed light on systemic issues in NSW that are contributing to people with mental illness dying prematurely.<br>• As a result of this project a working definitions guide has been created which contains information how to research mental health in coronial records. |
| **Lived Experience Steering Group and Framework (underway)**<br>• The Commission is developing a framework for promoting lived experience at all levels of the mental health and social support systems, informed by the findings of consumer-led and carer-led projects conducted in 2016-2017. | **2016-2017** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues | Principles 11 (a) through to 11 (e)(ii). | • Established the Consumer Lived Experience Project Steering Group.<br>• Framework (underway). | • In 2016 the Commission facilitated the establishment of a Consumer Lived Experience Project Steering Group, which has so far conducted two consultations in relation to participation, influence and leadership in NSW.<br>• The Commission will engage with consumer and carer advisory groups and networks via a co-design approach.<br>• The project's findings will inform the framework for promoting lived experience at all levels of the mental health and social support systems. | • This project ensures the representation of consumers and carers at all levels of the mental health and social support systems. |
| **Recovery and justice**<br>• This review will explore how a recovery and trauma informed approach can be implements in the criminal justice/ forensic setting. | **2016-2017** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (2)(c)** to take into account issues related to the interaction between people who have a mental illness and the criminal justice system. | **11 (d)** the promotion of good mental health and the effective provision of mental health services are the shared responsibility of the government and non-government sectors.<br><br>**11 (e)(i)** an effective mental health system requires a coordinated and integrated approach across all levels of | • Discussion Paper | • The Commission consulted with people lived experience and professionals working in the system.<br>• The Commission engaged Craze Lateral Solutions to do a literature review and conduct a survey with people with a lived | • TBD |

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| | | | | government and the non-government sector, including in the areas of health, housing, employment, education and justice. | | experience of mental illness and with professionals working with people who experience mental illness in the criminal justice system. | |
| **Forensic patients database**<br>• This database enables researchers to develop new understandings of how people move through the forensic system. | **2016-Ongoing** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (2)(c)** to take into account issues related to the interaction between people who have a mental illness and the criminal justice system. | **11 (d)** the promotion of good mental health and the effective provision of mental health services are the shared responsibility of the government and non-government sectors. | • N/A | • Worked in partnership with UNSW and gathered longitudinal data from the Mental Health Review Tribunal (MHRT) regarding the care, treatment, detention and release of forensic patients to enable researchers. | • Created an electronic (and searchable) database of MHRT files to support ongoing research. |
| **Mapping Social and Emotional Wellbeing policies**<br>• Preliminary work around mapping of policies across Government that relate to the mental health and wellbeing of Aboriginal people. | **2017** | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **12 (1)(d**) to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (2)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **11 (a)** people who have a mental illness, wherever they live, should have access to the best possible mental health care and support. | • Research paper | • The Commission engaged a consultancy team to undertake preliminary mapping of policies across Government that relate to the mental health and wellbeing of Aboriginal people at the end of 2016/17.<br>• This work provides a context for further engagement with agencies and the development of further work – for example around implementation challenges. | • TBD |
| **Disability inclusion** C<br>• The Commission participates in a number of activities to provide advice on how best to improve the inclusion and participation of people with disability, including people with mental illness, in the government sector. | **2012-Ongoing** | **12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health. | **12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers.<br><br>**12 (2)(b)** to take into account co-morbid issues associated with mental illness, such as drug and alcohol use and disability. | Principles 11 (a) through to 11 (e)(ii). | • N/A | • The Commission is a member of a number of committees and councils serving in an advisory capacity on a number of issues related to disability inclusion; these include:<br>- Participation in Disability Inclusion Implementation Committee.<br>- Participation in Disability | • Commission participation in a number of disability inclusion initiatives, ensures the explicit consideration of psychosocial disability when considering matters around disability inclusion. |

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| | | | | | | Employment Advisory Council.<br>• Participation in the Supported Decision Making Community of Practice. | |
| **National Disability Insurance Scheme (NDIS) Advocacy** C<br>• Through a series of submissions, forums and case studies the Commission has sought to advocate for the provision of NDIS support for people with a psychosocial disability. | **2013-Ongoing** | **12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers.<br><br>**12 (2)(b)** to take into account co-morbid issues associated with mental illness, such as drug and alcohol use and disability. | Principles 11 (a) through to 11 (e)(ii). | • Hunter NDIS and Mental Health Community of Practice forum<br>• *The NSW NDIS and Mental Health Analysis Partnership Project: Insights from the first two years of the NDIS rollout in the Hunter region*<br>• Short Film: *National Disability Insurance Scheme (NDIS) – mental health perspectives*<br>• *The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition: Submission by Mental Health Commission of New South Wales to the Joint Standing Committee on the NDIS* | • The Commission began work in 2013 with the MHCC at the NSW NDIS pilot site in the Hunter region to learn how the NDIS applies to people with psychosocial disability resulting from mental illness.<br>• MHCC developed a report *The NSW NDIS and Mental Health Analysis Partnership Project: Insights from the first two years of the NDIS rollout in the Hunter region* which included findings and recommendations to improve outcomes for people affected by mental health issues.<br>• This report has informed the Commission's advice to Government and NDIS with a view to refining the operation of the program in NSW, and has been given via *The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition* submission. | • The work of the Commission and MHCC in the Hunter region led to the establishment of a Community of Practice with regular forums where public sector agencies, community-managed organisations, consumers and carers share their experiences and hear from key organisations including the NDIS and Hunter New England LHD.<br>- The short film *National Disability Insurance Scheme (NDIS) – mental health perspectives* has had over 3800 views across Youtube and Facebook, is shown at Commission events and used by the NDIS. |

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| **Check up from the Neck Up**<br>The initiative, developed by the Commission and based on a successful US program, invited participants to take time out for a mental wellbeing assessment. | **2016-Ongoing** | **12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers. | Principles 11 (a) through to 11 (e)(ii). | • Community Event<br>- Martin Place October 2016<br>- Chatswood April 2017<br>- Easter Show April 2017 | • The event is a community engagement activity designed to reduce stigma and draw attention to the importance of mental wellbeing, in partnership with Local Health Districts, Flourish Australia Peer Workers and Lifeline Australia volunteers.<br>• There was a short five minute wellbeing screen undertaken with a mental health professional.<br>• At the Royal Easter Show Check-Up His Excellency General The Honourable David Hurley AC DSC (Ret'd), Governor of New South Wale, his wife Mrs Linda Hurley, The Hon. Tanya Davies MP, Minister for Mental Health , and The Hon. Scott Farlow MLC, Chair of the Parliamentary Friends of Mental Health were in attendance. | • There have been three events to date, including:<br>- Martin Place – Mental Health Month 2016: 155 screens.<br>- WayAhead Mental Health Expo Chatswood: targeting Chinese Community – 66 screens.<br>• Royal Easter Show: targeting rural and regional audiences – 198 screens. |
| **Suicide Data Improvement Project**<br>• The Commission worked in partnership with key stakeholders to discuss the merits of improving and formalising data sharing mechanisms on suicide. | **2016-Ongoing** | **12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health. | **12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers. | Principles 11 (a) through to 11 (e)(ii). | • TBD | • The Commission worked in partnership with key stakeholders including the Suicide Advisory Group, to discuss the merits of improving and sharing data on suicide for NSW, including:<br>- Consulted with other states regarding their current approaches<br>- Had detailed discussions with relevant government agencies, in particular NSW | • TBD |

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| | | | | | | Health and the Coroner's Office<br>- Commissioned research undertaking a qualitative analysis of coronial investigations in suspected and determined intentional deaths<br>- Considered the current context of suicide prevention initiatives at both the commonwealth and state level, including *LifeSpan*. | |
| **Undertaking key proactive media relations to raise awareness and reduce stigma** | **2012-Ongoing** | **12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers. | Principles 11 (a) through to 11 (e)(ii). | • TV appearances and features. Opinion columns. | • Examples include appearances on Q&A, profile of Deputy Commissioner Fay Jackson on ABC-TV's One Plus One; Sydney Morning Herald opinion columns. | • Being proactive in the media increases visibility of key messages on mental health to broad general audiences. |
| **Ensuring the voices of consumers and carers are heard** | **2012-Ongoing** | **12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues,<br><br>**12 (2)(d)** to engage and consult with:<br>(i) People who have a mental illness and their families and carers.<br>(ii) The government and non- government sectors.<br>(iii) The whole community. | Principles 11 (a) through to 11 (e)(ii). | • Personal stories playlist<br>• Written stories webpage | Creating dozens of video profiles (personal stories playlist and written profiles (personal stories webpage); and interviewing consumers for key publications such as the First Responders videos and promoting these to public and influencers. | • The following outcomes were measured:<br>- The videos on the Commission's stories playlist on youtube had 7100 views;<br>• The personal stories on the Commission's website had 35pprox.. 25,000 unique views since the website was launched. |

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| **Public Lecture**<br>• In partnership with Mind Australia, the Commission hosted a public lecture and leaders forum on 'The contribution to mental health reform by people who have experienced mental health challenges'.<br>• The lecture was given at the University of Sydney by Professor Larry Davidson, Professor of Psychology in the Department of Psychiatry at the Yale University School of Medicine. | **2013** | **12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | Principles 11(a) through to 11 (e)(ii). | • Free public lecture<br>• Leaders Forum | • A free public lecture 'The contribution to mental health reform by people who have experienced mental health challenges' was given at the university of Sydney by Professor Larry Davidson, Professor of Psychology in the Department of Psychiatry at the Yale University School of Medicine, where he serves as Director of the Program for Recovery and Community Health.<br>• The Lecture was followed by a leaders forum; a meeting of leaders from across the mental health sector to discuss: 'Recovery-oriented practice and the peer workforce'. | • The outcomes included:<br>- 180 attendees at the public lecture.<br>- More than 60 mental health sector leaders.<br>- Interview with Psychiatry Update/ 6Minutes and Australian Doctor.<br>- 3061 YouTube Views of video outputs from the event. |
| **Youth Week Pop Up Website** C | **2014** | **12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers. | **11 (b)** people who have a mental illness and their families and carers should be treated with respect and dignity.<br><br>**11 (c)** the primary objective of the mental health system should be to support people who have a mental illness to participate fully in community life and lead meaningful lives.<br><br>**11 (e)(ii)** an effective mental health system requires communication and collaboration between people who have mental illness and their families and carers, providers of mental health services, and the whole community. | • Pop-up website (no longer active). | • A new online resource for young people developed by the NSW Youth Advisory Council and the NSW Mental Health Commission was launched at the NSW Youth Week *Minding Our Mental Health* Forum. | The Makeamatesday website (no longer active) was developed in response to recent research in the Crossroads Report developed by EY and ReachOut.com by Inspire Foundation, which found more people, especially young people, are seeking online and peer-based services to support their mental health. |

| What we did (activity/initiative) | Date | Primary Function in relation to the Act | Secondary Function(s) in relation to the Act | Principle in relation to the Act | Output | How we did it | Outcomes |
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| **Youth Week Forum Minding Our Mental Health Forum** C | **2014** | **12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers. | **11 (c)** the primary objective of the mental health system should be to support people who have a mental illness to participate fully in community life and lead meaningful lives.<br><br>**11 (e)(ii)** an effective mental health system requires communication and collaboration between people who have mental illness and their families and carers, providers of mental health services, and the whole community. | • Forum. | • The Commission partnered with the Office of Communities and the NSW Young People's Advisory Committee to co-host the Minding Our Mental Health 2014 Youth Week Forum. | • Young people participated in workshops, panel discussions and an innovative theatre performance all with the aim of building their skills and confidence to support the mental health and wellbeing of their friends and family.<br>• 106 young people aged 15 to 25 attended the event at Parliament House on 1 April 2014. |
| **No Offence…**<br>• To increase awareness of mental health issues and to help reduce stigma and discrimination, the Commission hosted 'No Offence…', a night of comedy and conversation about stigma, language and mental health. | **2015** | **12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues.<br><br>**12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers. | **11 (b)** people who have a mental illness and their families and carers should be treated with respect and dignity.<br><br>**11 (c)** the primary objective of the mental health system should be to support people who have a mental illness to participate fully in community life and lead meaningful lives.<br><br>**11 (e)(ii)** an effective mental health system requires communication and collaboration between people who have mental illness and their families and carers, providers of mental health services, and the whole community. | • Comedy Night | • The event, held in June at the Cell Block Theatre in Sydney, featured comedians, media professionals and performers who shared inspiring and often hilarious insights into their experiences with mental illness and the role that language and stigma have played in their lives. | • The event provided an opportunity to have conversations about stigma, language and mental health through the medium of humour, further contributing the Commission's objective to reduce stigma about mental health. |
| **Parliamentary Showcase**<br>• Members of Parliament and their staff had the opportunity to meet with the leaders of programs that support people recovering from mental illness or trauma to live well in the community. | **2015-2016** | **12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues. | Principles 11 (a) through to 11 (e)(ii). | • Showcase of different community based work in mental health. | • Around 20 organisations featured their work at each event, with hands-on experiences that MPs could promote in their own constituencies. | • The showcase events promote the work of Community-based mental health organisations among Members of Parliament. |
| **Wellbeing Products**<br>• The Commission is continuing work to develop a suite of resources to support and | **2015-Ongoing** | **12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues, | Principles 11 (a) through to 11 (e)(ii). | • Workshop.<br>• Toolkit. | • As part of this work the Commission hosted an International Wellbeing Indicators Workshop, | • TBD |

| What we did (activity/initiative) | Date | Primary Function in relation to the Act | Secondary Function(s) in relation to the Act | Principle in relation to the Act | Output | How we did it | Outcomes |
|---|---|---|---|---|---|---|---|
| promote the adoption of a wellbeing focus across government and the community. | | associated with mental illness and discrimination against people who have a mental illness | **12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers. | | | bringing together international experts in wellbeing to identify tools available to measure wellbeing.<br>• In developing these tools we have worked closely with social designers from the University of Technology Sydney UTS and the Centre for Social Impact at the University of NSW. | |
| **Living Well@Work**<br>• The Living well @ work event was hosted in 2016 by the Commission as part of ongoing efforts to break down stigma and discrimination surrounding mental illness. | **2016** | **12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues,<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers. | Principles 11 (a) through to 11 (e)(ii). | • Community Forum | • Facilitated by ABC journalist Natasha Mitchell at Riverside Theatre, Parramatta, this 90 minute forum included insights from consumers and carers, and organisations like Mates in Construction, Western Sydney University, Flourish and SANE Australia. | • The video of this event is actively used by Employee Assistance Programs (EAPS), HR and other professionals as a guide to supporting and managing employees with mental health issues. |
| **Parliamentary Friends of Mental Health** C<br>• Since 2016 the Commission has partnered with NSW Parliamentary Friends of Mental Health to hold forums on topics of interest concerning mental health. | **2016-Ongoing** | **12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness. | **12 (1)(g)** to advocate for and promote the general health and well-being of people who have a mental illness and their families and carers. | Principles 11 (a) through to 11 (e)(ii). | • Parliamentary Friends of Mental Health forums | • Quarterly forums are held with specialist speakers on different issues related to mental health. | • The Parliamentary Friends of Mental Health Group serves to raise awareness and understanding of those affected by mental health, support community events as well as providing a forum for discussion on the issue in the NSW Parliament. |
| **Growing Up Digital** C<br>• The public forum, called *Growing Up Digital*, was organised by the Commission and chaired by digital journalist and founder of the Mamamia Women's Network, Mia Freedman to discuss how to support young people. | **2017** | **12 (1)(h)** to educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness. | **12 (1)(d)** to promote and facilitate the sharing of knowledge and ideas about mental health issues,<br><br>**12 (1)(f)** to advocate for and promote the prevention of mental illness and early intervention strategies for mental health.<br><br>**12 (1)(g)** to advocate for and promote the general health and well-being of people who | Principles 11 (a) through to 11 (e)(ii). | • Public Forum | • The event held a panel discussion on supporting the mental health of young people in an 'always on' digital environment with ReachOut.com CEO Jonathan Nicholas, Google Australia's Samantha Yorke and Mia Freedman, CEO Mamamia Women's Network. | • The following outcomes were measured from this event:<br>- Over 160 people were in attendance at Town Hall event.<br>- Over 300 views with ongoing dissemination of video to Human resources departments, department of education and youth |

| What we did (activity/initiative) | Date | Primary Function in relation to the Act | Secondary Function(s) in relation to the Act | Principle in relation to the Act | Output | How we did it | Outcomes |
|---|---|---|---|---|---|---|---|
| | | | have a mental illness and their families and carers. | | | | focused organisations. |
| **Living Well: Community Perspectives of Change**<br>• As part of the commitment to bringing the voice of lived experience and of the community into its work, the Commission held an online community survey in October 2016 to learn what changes people were observing or experiencing in mental health supports and services | **2016** | **12 (2)(d)** to engage and consult with:<br>(i) People who have a mental illness and their families and carers.<br>(ii) The government and non-government sectors.<br>(iii) The whole community. | **12 (1)(e)** to undertake and commission research, innovation and policy development in relation to mental health issues. | **11 (b)** people who have a mental illness and their families and carers should be treated with respect and dignity. | • *Living Well: Community perspectives of change*<br>• *Technical paper - Findings of the Commissions Evidence of Change 2016 community survey June 2017* | A diverse group of 1,510 people responded to the online survey, including people who had used mental health services for themselves or who supported a family member or friend, as well as people who provided mental health services or supports and those who funded and managed services. | • The findings were used to inform how agencies approach and communicate ongoing reform efforts. |

# Appendix Two

# Establishment of the Commission

The creation of a Mental Health Commission was a 2011 election commitment of the NSW Liberal/National Government.

In 2011, the NSW government set up the Taskforce to Establish a Mental Health Commission in NSW. The Taskforce undertook widespread consultation with consumers, carers, families, community members, service providers, clinicians, and government and non-government agencies.

The consultations revealed a desire for an independent body to be an authentic champion for reform. The community wanted a commission that would take a holistic approach to addressing the needs of people with mental illness across government and whole of life; with a broad scope to deal not only with mental health issues but also with a range of related diseases and disorders; focusing on systemic issues and having a strategic capacity and leadership role.

In November 2011, the government introduced the Mental Health Commission Bill which it said would deliver “an independent Mental Health Commission that will be a champion for mental health, ensure better accountability of mental health services and the use of mental health funds, and nurture innovation in our approach to mental health”.

The *Mental Health Commission Act* was passed in 2012 and commenced on 1 July 2012. John Feneley was appointed as the inaugural Mental Health Commissioner on 1 August 2012.

## Administrative Arrangements of the Commission

The Commission is an independent agency located within the NSW Government Health Cluster. It is not part of the NSW public health system and sits outside the range of entities that form NSW Health. Similar agencies within the Health Cluster that are also not part of NSW Health include the Health Professional Councils and the Health Care Complaints Commission. As with the NSW Mental Health Commission, these agencies’ roles include some aspect of statutory oversight of the public health system, although the Commission’s role also extends to other government portfolios.

As an independent agency, the Commission is required to meet the regulatory and policy requirements of government for the operation of public sector entities. The Commission strives to achieve high standards of corporate governance, including with respect to its internal policies, audit functions, and management of corporate risk. The Commission established an Audit and Risk Committee that provides independent advice to the Commissioner on the Commission’s financial, audit and risk management activities.

The Commission has a shared services agreement with FACS Business Services for accounting, payroll, taxation and asset administration services, and with First Focus Pty Ltd for the provision of information technology support services.

### *Budget*

While the Commission is an independent agency, it receives its funds from Treasury as a grant from the NSW Ministry of Health in the Ministry's capacity as the lead agency for the Health Cluster. Although the original commitment was for $30 million over the first 3 years of operation, in July 2012, NSW Treasury advised an annualised budget of $8.3 million over the four-year forward estimates.

Incorporated within the Commission's budget is the funding for three NGO contracts (Being NSW, Way Ahead and Mental Health Carers NSW) and beyondblue, the management of which was transferred to the Commission by the NSW Ministry of Health at the time of the Commission's establishment.

The Commission sought enhancements to its budget for both the 2016/17 and 2017/18 financial year to support sustaining its activities in line with the funding available during its first 3 years of operation. As noted in the table below, with further NGO grants transferred to the Commission from the Ministry of Health, the amount available to support the Commission's activity has decreased in real terms over the past 3 years by $1.4m.

| **Funding sources for the Commission** | **2014-15** | **2015-16** | **2016-17** |
|---|---|---|---|
| Base budget | $ 8,982,726 | $ 9,087,712 | $ 10,500,260 |
| Rollover from previous financial year | $ 845,000 | $ - | $ - |
| Add: Additional funding received | $ - | $ 507,200 | $ - |
| Special enhancement for *Living Well* activities | $ 952,000 | $ 930,000 | $ - |
| Total: | $ 10,779,726 | $ 10,524,912 | $ 10,500,260 |
| Less: NGO funding | ($2,565,497) | ($3,107,018) | ($3,712,181) |
| Total funding less NGO funding | $8,214,229 | $7,417,894 | $6,788,079 |

## Structure and Staffing

The Commission's legislation commenced on 1 July 2012 and John Feneley was appointed as the inaugural Mental Health Commissioner on 1 August 2012.

The Commission's first part-time Deputy Commissioners were appointed in March 2013. The Commission currently has five part-time Deputy Commissioners, Dr Robyn Shields AM, Ms Fay Jackson, Ms Karen Burns, Dr Martin Cohen, and Mr Alan Sparkes AM. Both Ms Jackson and Mr Sparkes have a lived experience of mental illness. The appointment of a Commissioner or Deputy Commissioner/s with a lived experience of mental illness is required by the *Act* and

recognises the value of lived experience in informing system reform and in establishing the Commission's credibility with the mental health and wider NSW community.

The Commissioners meet approximately every two months to ensure that Deputies have a role in informing the ongoing direction and work of the Commission. In addition the Deputies play a significant role in representing the Commission and extending the Commission's outreach to the community. Of particular significance is the lead work undertaken by Ms Jackson and Mr Sparkes (and previously Mr Foxlewin) in the area of lived experience of mental illness and the lead work undertaken by Dr Shields in relation to Aboriginal communities.

### *Community Advisory Council*

As required under the legislation, a Community Advisory Council was also initially established in March 2013. On advice of the Commissioner, the then Minister for Mental Health appointed 16 people who reflect the diversity of the NSW community. The Council's role is to provide advice to the Commission on mental health issues either referred to it by the Commission or of concern to the members.

The Council's membership was refreshed in November 2016, with 17 members appointed including Ms Jenni Campbell as chair. The Council meets once every 3 months to discuss and provide advice on mental health issues.

### *Staffing*

The Commission's initial organisational structure and associated budget were developed by the NSW Ministry of Health prior to the Commissioner's appointment. Similarly, the Ministry developed the position description for the Commissioner's role and this guided its subsequent grading. Initial attempts by the Commissioner to enhance the proposed structure with more senior positions were frustrated by a public freeze on Senior Officer positions.

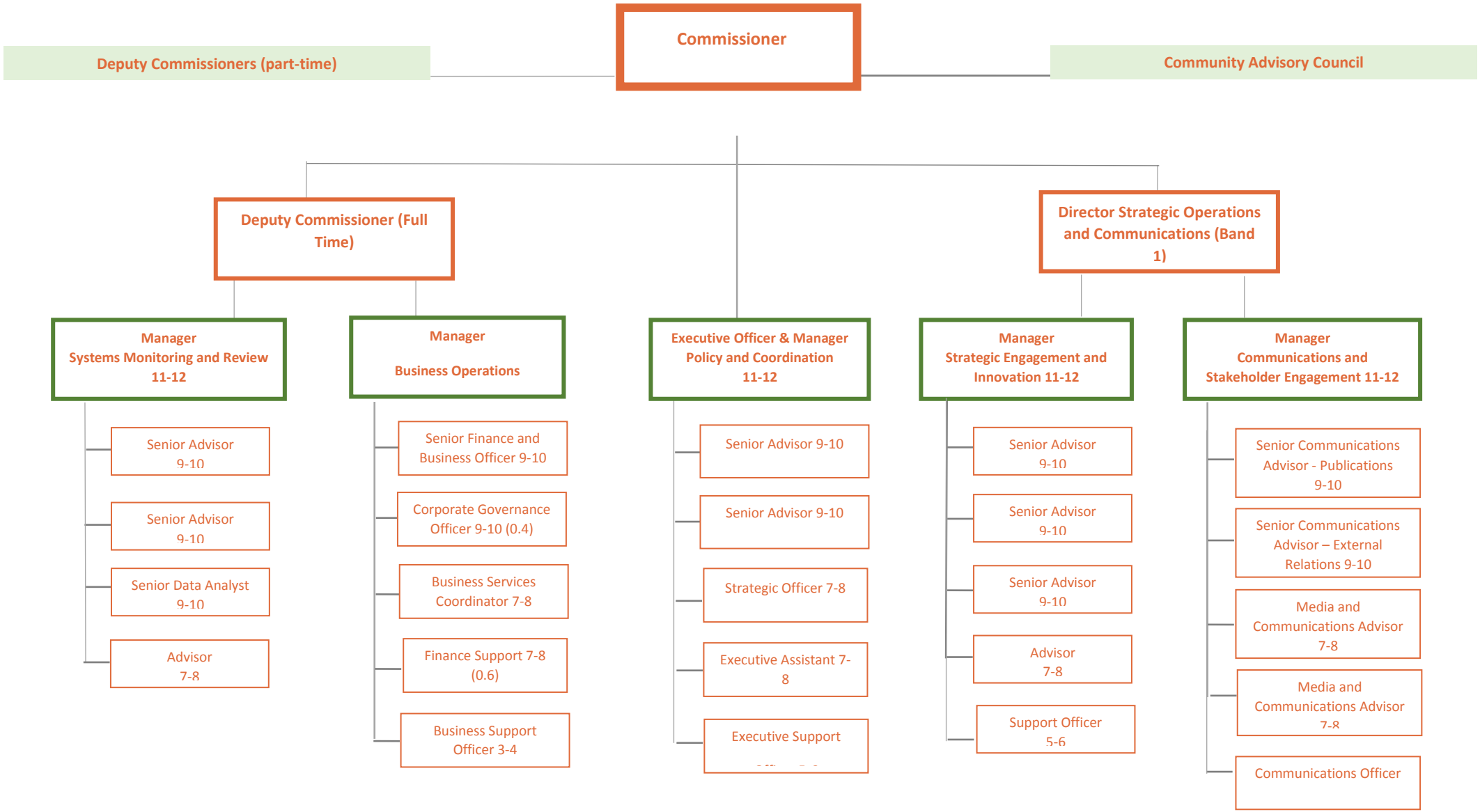
In late 2015 the Commission undertook an assessment of its staff capability and skills mix to ensure that it is appropriately positioned to meet its statutory functions and deliver on its forward work program. In recognition that the staffing profile necessary to meet its functions required the appointment of additional senior executives, a minor restructure was completed in 2016. This saw the appointment of a Full-Time Deputy Commissioner, the creation of Director Strategic Operations and Communications, and deletion of Executive Director.

The resulting structure (chart below) sees the full-time Deputy Commissioner overseeing the work of the Systems Monitoring & Review and Business Operations teams; the Director Strategic Operations and Communications overseeing the work of the Strategic Engagement & Innovation and Communications & Stakeholder Relations teams; with the Policy & Co-ordination team reporting to the Commissioner.

The Commission currently has an FTE of 29 (not including Commissioner and Full-time Deputy Commissioner) with 30 staff, of whom 19 are appointed and 10 are agency contractors.

The Commission will continue to manage its recruitment activity so as to retain a flexibility to expand and contract in response to new priorities and the capability and capacity requirements for specific reviews of programs and services that it may undertake.

Mental Health Commission of New South Wales



**REVIEW OF THE COMMISSION'S LEGISLATION**

**COMMISSION PROPOSED CHANGES TO LEGISLATION**

- S6 – Amend to enable the Commissioner to be appointed for a period of up to 10 years rather than a maximum of 2 terms (of maximum 5 years each). This would provide consistency with the amendments made to appointments of Deputy Commissioners to provide for a maximum period of appointment rather than number of 'terms'.
- S9 – Amend such that the Commission reports to a Parliamentary Committee rather than to a Minister. This would better reflect the whole of government nature of the role of the Commission as well as provide a mechanism for broadening the understanding of mental health and wellbeing within parliament.
- S12(1)(e) – Amend to read as follows – 'to undertake, ***facilitate***, and commission research, innovation and policy development in relation to mental health'. This reflects that much of the Commission's work is about empowering others and facilitating discussions/connections rather than always directly undertaking or commissioning the work.
- S12 – Provide that the Commission can review the strategic plan and prepare any appropriate amendments and provide to the Minister for approval. This could be modelled on provisions in the Queensland Commission legislation (s27)
- S16 – Strengthen the ability of the Commission to request information from agencies.
  - A possible model could be the slightly stronger wording of the Queensland Commission Act (s36) which provides that *the department or unit must provide the information requested unless— (a) its disclosure is prohibited under an Act; or (b) it is impracticable to provide the information*. Further, *if the department or unit decides not to provide the information, the department or unit must advise the commission of its reasons for not providing the information*.
  - S12(1)(c) provides that the Commission may review *mental health services and other services and programs provided to people who have a mental illness, and other issues affecting people who have a mental illness.* While many such reviews can be effectively undertaken utilising the normal data request provisions, in relation to some reviews, particularly those of any service, the Commission may require direct access to both the services physical premises and information related to the service. In those circumstances the Commission should:
    (a) Notify the Minister of its intent to commence the relevant review
    (b) Seek the Minister's approval in relation to specific information requests which may include:
      - Ability to enter and inspect any premises
      - Inspect any document or thing in connection to the service
- S17 – provide that Government agencies must respond to any report by the Commission. This could be modelled on provisions in Queensland Commission legislation (s32)

- Strengthen mechanisms for co-operation with other relevant agencies. For example there is currently no legislative mechanism to allow for the Commission to refer matters to or work jointly with key agencies such as the HCCC. Given the respective review functions of the Commission and HCCC, there would be occasions where it would be beneficial and more efficient for the Commissions to work together in undertaking a review regarding a particular systemic issue.

**APPENDIX: Legislative (and other) Models for Mental Health Commissions**

*Note: This summary excludes NSW*

## 1. Queensland

The Queensland Mental Health Commission is established under the *Queensland Mental Health Commission Act 2013* (Qld).

The main functions of the Commission are:

- To prepare a whole-of-government strategic plan (s 11 (1)(a)).
- To monitor and report to the Minister on implementation of the whole-of-government strategic plan (s 11 (1)(b)).
- To review the whole-of-government strategic plan (s 11 (1)(c)).
- To review, evaluate, report and advise on –
    - The mental health and substance misuse system (s 11 (1)(d)(i)).
    - Other issues affecting relevant persons (s 11 (1)(d)(ii).
    - Issues affecting community mental health and substance misuse (s 11 (1)(d)(iii)).
- To promote and facilitate the sharing of knowledge and ideas about mental health and substance misuse issues (s 11 (1)(e)).
- To undertake and commission research in relation to mental health and substance misuse issues (s 11 (1)(f)).
- To promote and report strategies that –
    - Prevent mental illness and substance misuse (s 11 (1)(g)(i)).
    - Facilitate early intervention for mental illness and substance abuse (s 11 (1)(g)(ii)).
- To 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 (s 11 (1)(h)).
- To support and promote social inclusion and recovery of people with a mental illness or who misuse substances (s 11 (1)(i)).
- To promote community awareness and understanding about mental health and substance misuse issues, including for the purpose of reducing stigma and discrimination (s 11 (1)(j)).
- To take other action the commission considers appropriate to address the needs of relevant persons (s 11 (1)(k)).

In exercising its functions, the commission must:

- Focus on systemic mental health and substance misuse issues (s 11 (2)(a)).

- Take into account comorbid issues including disability, chronic disease and homelessness (s 11 (2)(b)).
- Take into account issues for people with mental health and substance misuse issues in the criminal justice system (s 11 (2)(c)).
- Engage and consult with –
    - People with mental health or substance misuse issues, and their families, carers and support persons (s 11 (2)(d)(i)).
    - Hospital and Health Boards (s 11 (2)(d)(ii)).
    - The government, non-government and private sectors (s 11 (2)(d)(iii)).
    - Other members of the community to the extent the commissioner considers appropriate (s 11 (2)(d)(iv)).
- Take into account the particular views, needs and vulnerabilities of different sections of the Queensland community, including –
    - Aboriginal and Torres Strait Islander communities (s 11 (2)(e(i)).
    - Culturally and linguistically diverse communities (s 11 (2)(e)(ii)).
    - Regional and remote communities (s 11 (2)(e)(iii)).
    - Other groups at risk of marginalisation and discrimination (s 11 (2)(e)(iv)).
- Take into account contemporary evidence and relevant policy and strategic frameworks (s 11 (2)(f)).

The commission must prepare a whole-of-government strategic plan for approval by the Minister (s 25(1)).

The commission must facilitate implementation of the whole-of-government strategic plan (s 26 (a)); and monitor and report to the Minister on its implementation (s 26 (b)).

The commission must review the whole-of-government strategic plan at least once every 5 years, or earlier if directed by the Minister (s 27 (1)(a)); and prepare any appropriate amendments and submit them to the Minister for approval (s 27 (1)(b)).

The commission must prepare special report if directed by the Minister. (s 28)

The commission may prepare ordinary reports, which are to be given to the Minister (s 29 and s 30).

If in an ordinary report, the commission makes a recommendation that relates to a relevant agency, **the agency must respond** to the commission in writing (s 32).

The commission and relevant agencies must work cooperatively in the exercise of their respective functions (s 34 (1)).

Relevant **agencies must**, in exercising their functions:

- Have **regard to the whole-of-government strategic plan and the guiding principles** (s 34 (2)(a)); and
- **Consult** with the commission on their activities, expenditure and initiatives as required under the whole-of-government strategic plan (s 34 (2)(b)).

This does not create legally enforceable obligations (s 34 (4)).

The commission may request a department or unit to provide information the commission requires to perform its function (s 36 (2)). The department or unit **must provide the information** requested unless –

- Its disclosure is prohibited under an Act (s 36 (3)(a)); or
- It is impracticable to provide the information (s 36 (3)(b)).

If the department or unit decides not to provide the information, it must advise the Commission of its reasons (s 36 (4)).

*The Act* establishes the Queensland Mental Health and Drug Advisory Council (s 37) to provide advice to the Commission on mental health or substance misuse issues (s 38 (a)) and make recommendations in relation to the Commission's functions (s 38 (b)).

The Queensland legislation is available at:
https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/Q/QldMentalComA13.pdf

### 2. Western Australia

In 2015 the Mental Health Commission and the Drug and Alcohol Office amalgamated. This is *not* a statutory body.

The Commission's website states that it 'funds the provision of support services and programs to the community, but also directly provides some services.'

The Commission is guided by the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025: Better Choices. Better Lives*.

The Plan is available at: https://www.mhc.wa.gov.au/media/1834/0581-mental-health-planprintv16acc-updated20170316.pdf

WA's mental health legislation, which does not refer at all to the Commission, is the *Mental Health Act 2014* (WA).

The legislation is available at:

https://www.slp.wa.gov.au/legislation/statutes.nsf/main_mrtitle_13537_homepage.html

### 3. South Australia

The SA Mental Health Commission is established in 2015 by the *Public Sector (Establishment of South Australian Mental Health Commission) Proclamation 2015* (SA).

The proclamation is available at:

https://www.legislation.sa.gov.au/LZ/V/P/2015/PUBLIC%20SECTOR%20(ESTABLISHMENT%20OF%20SOUTH%20AUSTRALIAN%20MENTAL%20HEALTH%20COMMISSION)%20PROCLAMATION%202015_29.10.2015%20P%204745.aspx

The Commission is developing the *SA Mental Health Strategic Plan* which, according to the Commission's website, 'will look at how South Australians can strengthen their mental health and wellbeing and access quality care and support when required.'

SA's mental health legislation, which does not refer at all to the Commission, is available at: https://www.legislation.sa.gov.au/LZ/C/A/MENTAL%20HEALTH%20ACT%202009/CURRENT/2009.28.UN.PDF

### 4. Victoria

The Mental Health Complaints Commissioner was established under the *Mental Health Act 2014* (Vic) (s 226 (1)). It is a complaints body.

The functions of the Commissioner are:

- To investigate complaints relating to service providers (s 228 (a)).
- To endeavour to resolve complaints in a timely manner (s 228 (b)).
- To issue compliance notices (s 228 (c)).
- To consult (s 228 (d)).
- To provide advice relating to a complaint (s 228 (e)).
- To make an accessible complaints procedure (s 228 (f)).
- To provide information, education and advice to service providers (s 228 (g)).
- To assist consumers to resolve complaints (s 228 (h)).
- To review issues arising out of complaints, and to make recommendations (s 228 (j)).
- At the request of the Minister, to investigate into, and report on, any matter relating to mental health service providers (s 228 (k)).

The Commissioner has the power to do all things that are necessary or convenient to be done for the performance of his or her functions (s 229 (1)).

The Commissioner or an investigator may enter the premises of a mental health service provider for the purposes of investigating a complaint (s 254 (1)).

The Commissioner or an investigator who enters a premises for the purpose of an investigation may:

- Inspect, examine, make enquiries at the premises (s 254 (2)(a)).

- Inspect or examine anything, including a document (s 254 (2)(b)).
- Take photographs or make audio visual recordings at the premises (s 254 (2)(d)).
- Use any equipment at the premises (s 254 (2)(e)).
- Make copies of, or take extracts from, any document kept at the premises (s 254 (2)(f)).
- Speak to any person receiving mental health services (s 254 (2)(g)).
- Direct a person employed at the premises to produce a document (s 254 (2)(h)).
- Direct a person at the premises to answer any questions (s 254 (2)(i)).
- Do any other thing that is reasonably necessary for the purposes of performing his or her functions (s 254 (2)(j)).

Following an investigation, the Commissioner must prepare a report (s 257 (1)(c)), which may be provided to the Minister (s 257 (4)(a)), and may be published (s 259 (1)).

Mental health service providers and staff must provide reasonable assistance to the Commissioner (s 263).

The legislation is available at:

http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/0001F48EE2422A10CA257CB4001D32FB/$FILE/14-026aa%20authorised.pdf

### 5. Australia

The National Mental Health Commission was established in January 2012 by the Prime Minister to increase the transparency and accountability in mental health through the production and publication of an annual mental health and suicide prevention report card. Two national Report Cards on Mental Health and Suicide Prevention were produced, in 2012 and 2013. A copy of the Prime Ministers establishment letter can be found at:
http://mentalhealthcommission.gov.au/media/66201/PM%20Statement%20of%20Expectations.pdf
The NMHC is not a statutory body and when established it reported to the Minister for Mental Health and Ageing on day-to-day issues, with agency reporting to the Prime Minister. It was located within the portfolio of the Department of Prime Minister and Cabinet. In 2013 this was changed to report to the Minister for Health, and was located under the Department of Health.

In January 2014 it was tasked by the Commonwealth Government with conducting a national review of mental health programs and services. The report of this review was submitted to the Minister for Health on November 39, 2014 titled *Contributing Lives, Thriving Communities – Report of the National Review of Mental Health Programmes and Services*.

The report is available at: http://www.mentalhealthcommission.gov.au/our-reports/contributing-lives,-thriving-communities-review-of-mental-health-programmes-and-services.aspx

## 6. New Zealand

The Health and Disability Commissioner took over the functions of the Mental Health Commission, which was de-established in 2012.

The *Health and Disability Commissioner Act 1994* (New Zealand) provides for the appointment of a Mental Health Commissioner, within the Office of the Health and Disability Commissioner (s 9).

Functions of the Health and Disability Commissioner include:

- To prepare a draft Code of Health and Disability Services Consumers' Rights, and provide to the Minister (s 14 (1)(a)).
- To review the Code and make any recommendations to the Minister (s 14 (1)(b)).
- To promote respect for and observance of the rights of health consumers and disability consumers (s 14 (1)( c)).
- To promote awareness of the rights of health consumers and disability services consumers (s 14 (1)( c)).
- To make public statements and publish reports in relation to any matter affecting the rights of health consumers or disability services consumers (s 14 (1)(d)).
- To act as the initial recipient of complaints about health care providers and disability services providers, and ensure that each complaint is appropriately dealt with (s 14 (1)(da)).
- To investigate, on complaint or own initiative, any action that appears in breach of the Code (s 14 (1)(e)).
- Where necessary, to refer complaints or investigations to the Director of Public Prosecutions (s 14 (1)(f)).
- To make recommendations (s 14 (1)(g)).
- To prepare guidelines for the operation of advocacy services (s 14 (1)(h)).
- To make suggestions (s 14 (1)(i)).
- On own initiative or request of the Minister, advise on the rights of health or disability services consumers, or advise on the administration of the Act (s 14 (1)(j)).
- Report to the Minister from time to time on the need or desirability of action to better protect the rights of consumers (s 14 (1)(k)).
- To receive and invite representations from members of the public and any other body (s 14 (1)(l)).
- To gather information to assist carrying out the Commissioner's functions (s 14 (1)(m)).
- To monitor mental health and addiction services and advocate improvements (s 14 (1)(ma)).
- To perform such functions as directed by the Minister (s 14 (1)(o)).

The Commissioner is to establish and maintain links with consumers and service providers, and with other bodies and organisations (s 14 (2)).

At 5 year intervals, the Commissioner is to review the operation of the Act, and report the findings to the Minister (s 18).

The NZ legislation is available at:
http://www.legislation.govt.nz/act/public/1994/0088/latest/DLM333584.html

### 7. Canada

The Mental Health Commission of Canada was established in 2007. In 2012 it released a mental health strategy – *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*. The Commission's website states that the strategy 'aims to help improve the mental health and well-being of all people living in Canada, and to create a mental health system that can truly meet the needs of people living with mental health problems and illnesses and their families.' The Commission recently released the *2017 – 2022 Strategic Plan*. The pans and annual reports are available at:
http://www.mentalhealthcommission.ca/English

### 8. Ireland

The Mental Health Commission is a statutory body under the *Mental Health Act 2001* (Ireland).

*The Act* states that the Commission's principal functions are to promote, encourage and foster high standards and good practices in the delivery of mental health services and to protect the interests of involuntary patients (s 33(1)).

The Commission has the following functions:

- To appoint people to be members of Mental Health Tribunals to review the detention of involuntary patients (s 33(3)).
- To assign a legal representative for the patients (s 17).
- To establish a panel of consultant psychiatrists to carry out independent medical examinations (s 33(3)).
- To develop codes of practice for the guidance of people working in mental health facilities (s 33(3)).
- To maintain a register of approved mental health inpatient facilities (s (64).
- To appoint an Inspector of Mental Health Services (s 50) to inspect mental health facilities (s 51).
- To **make rules regulating** ECT (s 59(2)) and **seclusion** and mechanical **restraint** (s 69(2)).

The legislation is available at:
http://www.irishstatutebook.ie/eli/2001/act/25/enacted/en/index.html

### 9. Scotland

The Mental Welfare Commission for Scotland was established in 1960 under legislation that is now inactive. The Commission continues to exist in accordance with the *Mental Welfare (Care and Treatment) (Scotland) Act 2003*.

*The Act* also regulates the treatment of people with a mental health issue, and establishes a Mental Health Tribunal, and sets out its functions.

Under *the Act*, the Commission has the following duties and functions:

- To monitor the operation of the Act and promote best practice (s 5).
- To report on the operation of the Act (s 6).
- To bring matters to the attention of Ministers, a local authority, a Health Board and others (s 7 and s 8).
- To give advice to Ministers, a local authority, a Health Board and others (s 9).
- To publish information and guidance (s 10).
- Where it considers appropriate, to investigate and make recommendations in circumstances such as:
    - Where a patient may have been unlawfully detained in hospital.
    - Where a patient is subject to a CTO or other orders.
    - Where a patient may have been ill-treated or neglected or subject to deficiency of care. (S 11)
- To secure authorised visits to patients who are detained in hospital or are subject to a CTO or other orders (s 13).
- To have an authorised person interview a patient (s 14).
- To have an authorised person conduct a medical examination of a patient (s 15).
- To require a patient's medical records to be produced and inspected (s 16).

The legislation is available at: http://www.legislation.gov.uk/asp/2003/13/contents

The Commission also has functions under the *Adults with Incapacity (Scotland) Act 2000*, as follows:

- To exercise protective functions in respect of an adult with incapacity.
- To visit an adult with incapacity, and bring their welfare to the attention of the Health Board or local authority.

- To investigate circumstances where they believe the adult's welfare is at risk, or their property is at risk of loss or damage.

The legislation is available at: http://www.legislation.gov.uk/asp/2000/4/contents

**10. California**

The Mental Health Services Oversight & Accountability Commission was established following the passing in 2004 of *Proposition 63, the Mental Health Services Act (MHSA)*. The Commission was established under the *Welfare and Institutions Code 5814*.

The role of the Commission is to oversee the implementation of the MHSA, to develop strategies to overcome stigma, and to advise the Governor or the Legislature on mental health policy.

The Commission consists of government, community and employer representatives, and includes people with or family members of people with a severe mental illness (s 5845 (a)). All meetings of the Commission are open to the public (s 5845) (d)(1).

The Commission may develop strategies to overcome stigma and discrimination (s 5845 (d)(8)).

The Commission may, at any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness (s 5845 (d)(9)).

The Commission may refer issues to the State Department of Health Care Services that relate to the performance of a county mental health program (s 5845 (d)(10)).

The Commission may work with the State Department of Health Care Services and the California Mental Health Planning Council in designing a plan for a coordinated evaluation of client outcomes in the community-based mental health system (s 5845 (s)(12)).

Each county mental health program shall prepare and submit a three-year program and expenditure plan, and annual updates, to the Commission (s 5847 (a)).

The code is available at:

https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=5.&title=&part=3.7.&chapter=&article=

11. **California**

Californian law requires all counties to have a mental health board or commission. The boards have an oversight role in the administration and provision of mental health services.

An example is LA County Department of Mental Health. Its Mental Health Commission states that it reviews and evaluates the community's mental health needs, services, facilities and special programs.

12. **Some US states**

Some US states have a Commissioner of mental health, but this seems to be the title of the head of the agency responsible for providing health services relating to mental health and substance abuse. Examples include Vermont, Alabama, Oklahoma.

**13. Virginia USA**

Virginia *had* a Commission on Mental Health Law Reform

The Commission was appointed by the Chief Justice of the Supreme Court, in October 2006. It was an initiative of the Court, and was funded by the Court. The work of the Commission concluded in 2011.

The Commission was directed to conduct a comprehensive examination of Virginia's mental health laws and services and to study ways to use the law more effectively to serve the needs of people with mental illness, while respecting the interests of their families and communities.

Goals of reform included improving access to mental health, mental retardation and substance abuse services, reducing criminalisation of people with mental illness, making the process of involuntary treatment more fair and effective, enabling consumers to have more choice over the services they receive, and helping young people with mental health problems before the problems spiral out of control.

The Commission issued a preliminary report and two progress reports. The reports are available at: http://www.courts.state.va.us/programs/concluded/cmh/home.html

# APPENDIX 4
# ORC ONLINE SURVEY REPORT

# MENTAL HEALTH COMMISSION REVIEW – ONLINE CONSULTATION SURVEY

## Summary report

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# Contents

# 1 Report Summary

### 1.1.1 Background

As part of a statutory review of the Mental Health Commission of New South Wales (the Commission), the Ministry of Health (the Ministry) engaged OCR International to conduct an online consultation survey. This was designed to collect feedback from a broad range of stakeholders in the form of pre-structured submissions. Through this instrument, stakeholders' views were sought on:

- the extent to which the work of the Commission had met the objectives, functions and principles outlined in the *Mental Health Commission Act* (the Act)
- the Commission's future role, functions, principles and priorities.

This is ORC International's report on the results of the online consultation survey.

## 1.2 Methodology

The project was carried out in compliance with ISO 20252 and membership requirements for AMSRO and AMSRS. It employed an open, public, online consultation survey instrument. It was open to submissions from 5 October to 7 November 2017, and accessible via a hyperlink on the Ministry of Health's website.

The questionnaire was designed by ORC International, together with the Ministry, and structured around the Act. It contained a mixture of closed questions, to provide quantitative data, and open-ended questions, to provide opportunities for respondents to phrase their own responses.

Most of the closed questions were 5-point agreement scales, there was one 5-point extent scale, and one question which asked respondents to rank their three most important items (future functions) from a selection.

For the analysis of free-text comments, coding frames were developed for each of the open-ended questions, based on an exploration of the themes and topics that emerged for each question. These coding frames were modified during the coding process, as new themes or topics emerged.

A total of 753 responses were submitted to the online consultation. The final sample contained 303 responses from representatives of organisations (40%), and 450 from individual respondents (60%).

It is important to note that some consumer responses may have been more influenced by their personal experiences of the mental health sector than their knowledge of the Commission's work.

## 1.3 Overview of feedback on functions, Charter letter priorities, operations and principles

Across all the areas measured, respondents rates of agreement (agree/ strongly agree) ranged from 26% to 67%, and disagreement rates (disagree/ strongly disagree) ranged from 14% to 48%.

Overall, the areas that respondents thought the Commission had performed best in were:

- working to the principle that people with mental illness should have access to the best possible care, are treated with dignity and respect, and are supported to live fully in community life and lead meaningful lives (67% positive)
- fulfilling its function to produce an effective strategic plan (61% positive)
- exercising its function to focus on system-wide mental health issues (58% positive)
- exercising its function to effectively engage and consult NSW Government (58% positive).

It was perceived as having been least effective at:

- ensuring that the NDIS take appropriate account of the needs of people with psychosocial disability as a consequence of mental illness (48% negative) [Charter letter priority]
- enhancing integration and coordination across the sector, including in the areas of health, housing, employment, education and justice (38% negative) [Principle].

The overall results for all functions, Charter letter priorities, operations and principles are shown in Figure 1 to Figure 4, with the best performing and least effective ratings marked with circles on the right.

Figure 1: Functions under the Act, overall agreement levels that the Commission has...

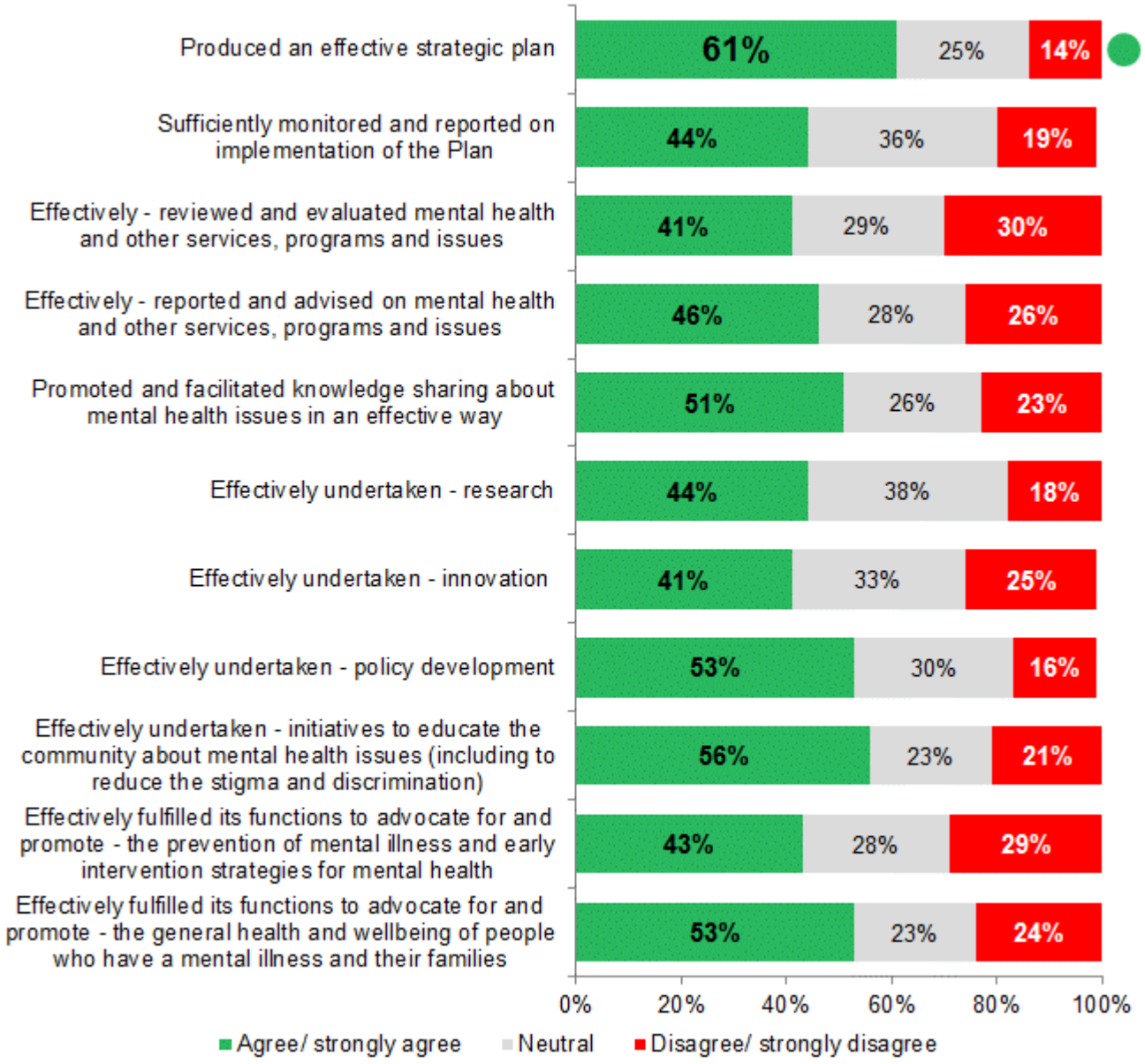



Figure 2: Ministerial Letter priorities, overall agreement levels that the Commission has...

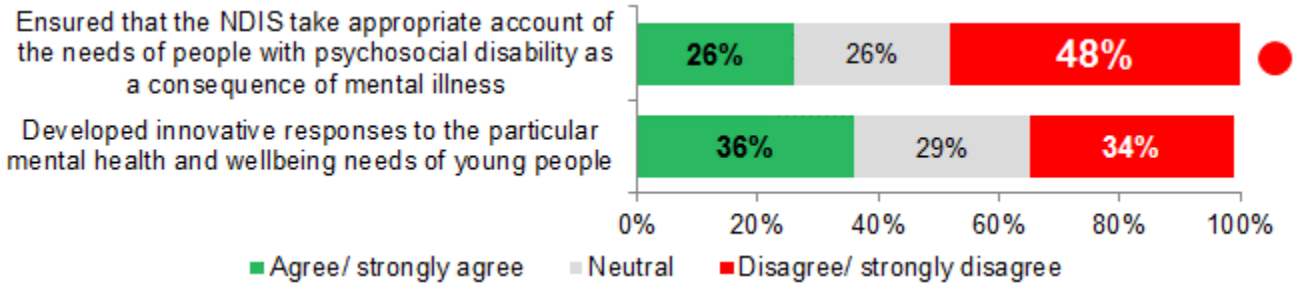


Figure 3: Operations – exercising the Commission's functions, overall agreement levels that the Commission has...

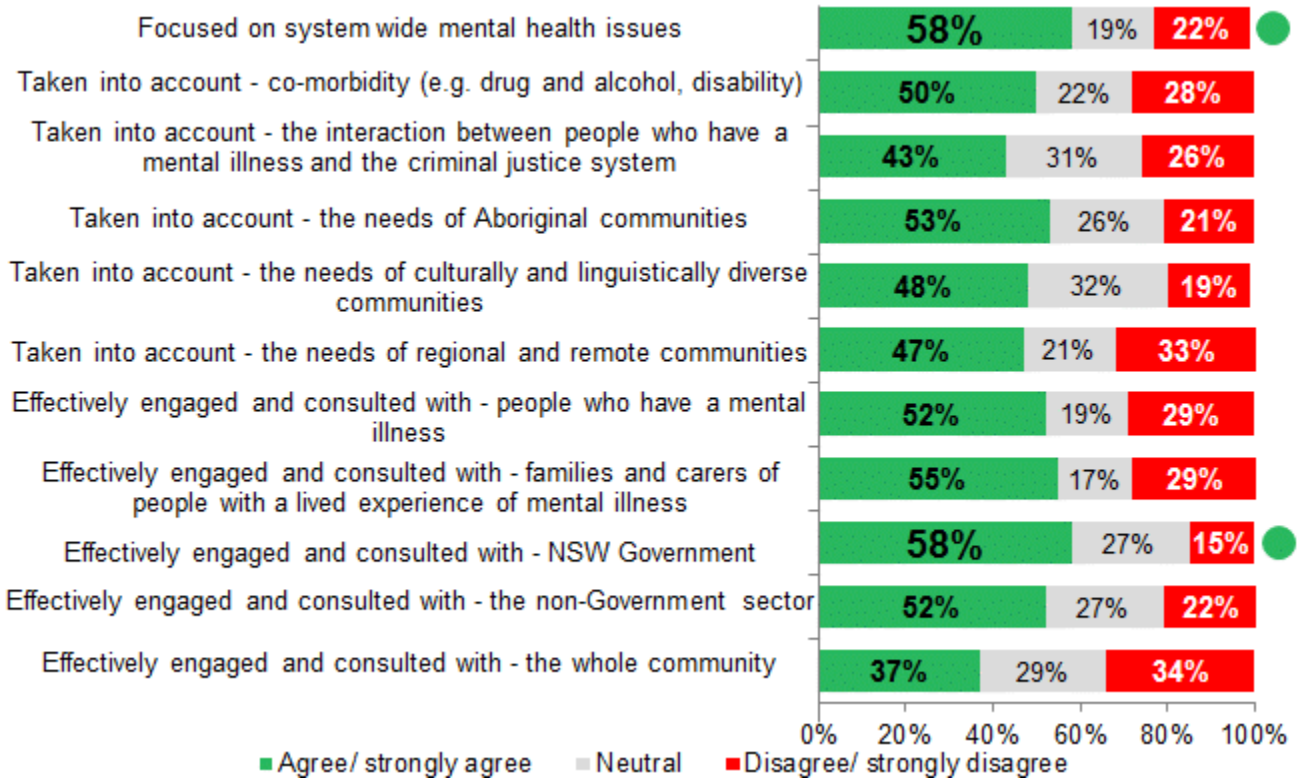
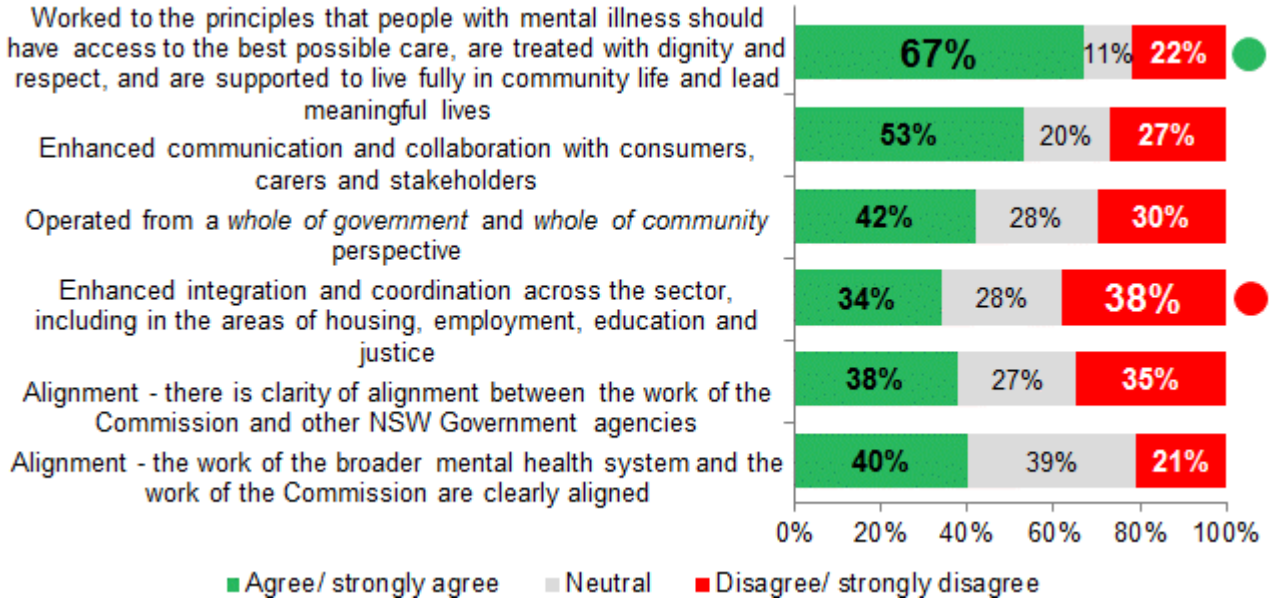



Figure 4: Principles, overall agreement levels that the Commission has...

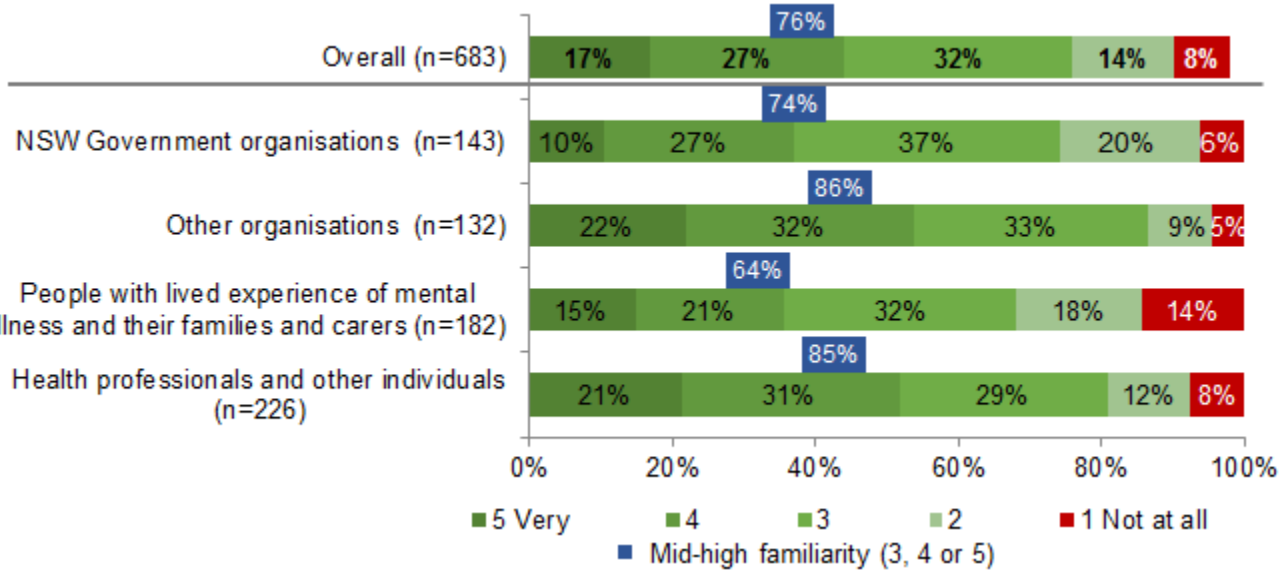


## 1.4 Familiarity with the work of the Commission

Respondents were first asked to rate the extent of their familiarity with the work of the Mental Health Commission. About three quarters of the 683 respondents who answered this question had a mid to high level of familiarity, giving a rating of 3 to 5 (76%), while 8% indicated that they were not familiar with the Mental Health Commission's work.

Non-NSW Government organisations, and health professionals and other (non-consumer) individuals were most familiar with the Commission (86% and 85% had mid to high levels of familiarity, respectively), while people with lived experience of mental illness and their families and carers were least familiar (64% had mid to high levels of familiarity).

Figure 5: Extent of familiarity with the work of the Commission, overall and by high level organisation and individual groupings (n=683)




## 1.5 Functions under the Act

Between two-fifths and three-fifths of respondents agreed/ strongly agreed that the Commission had effectively undertaken each of the specified functions (41%-61%).

The function areas that respondents were most positive about were:

- the production of an effective strategic plan (61%)
- initiatives to educate the community about mental health issues (including to reduce the stigma and discrimination) (56%)

- policy development (53%)
- the advocacy and promotion of the general health and wellbeing of people who have a mental illness and their families (53%).

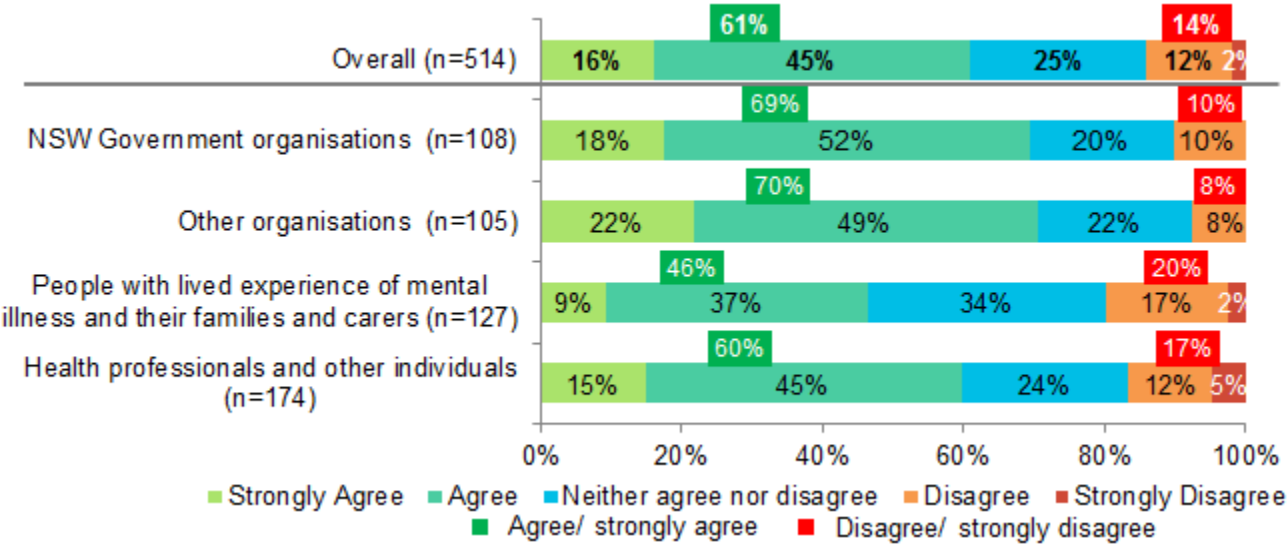
Respondents were least positive about the Commission's role in reviewing and evaluating mental health and other services, programs and issues (41%), and in undertaking innovation (41%).

## 1.5.1 The Strategic Plan

### 1.5.1.1 Drafting of the Strategic Plan

Submissions from NSW government organisations (69%) and other organisations (70%) were the most likely to believe that the Commission's strategic plan was effective; and people with lived experience of mental illness and the carers were the least likely (46%). Submissions from the remaining group of individuals were positioned somewhere between the two (at 60%).

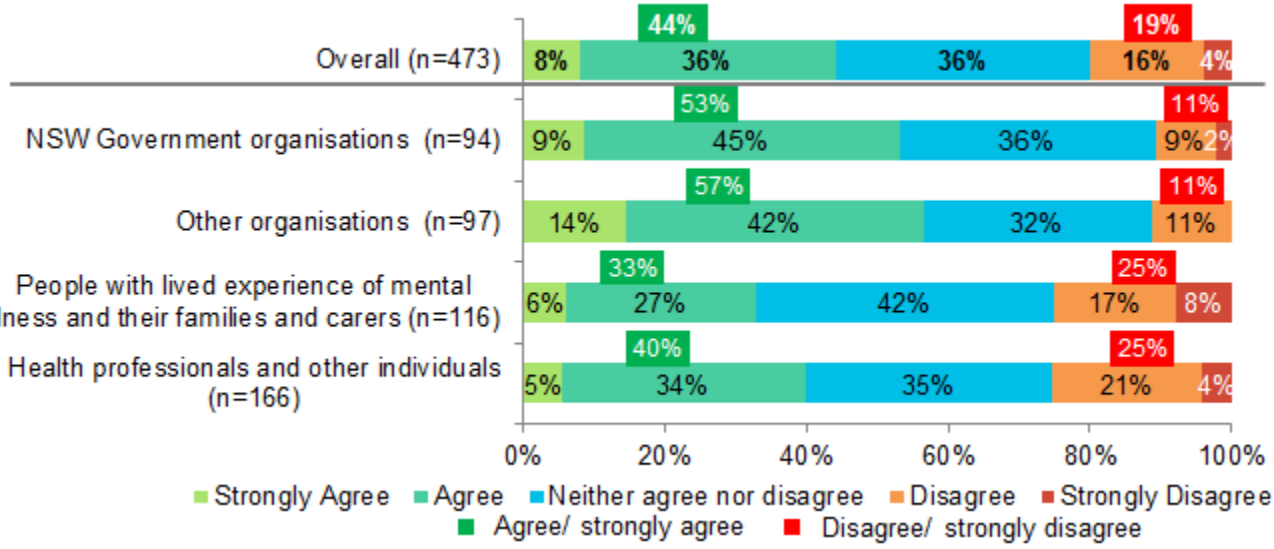
Figure 6: Level of agreement that the Commission *produced an effective strategic plan*, overall and by high level organisation and individual groupings (n=514)



### 1.5.1.2 Monitoring of the Strategic Plan

Whilst submissions were less positive about the way in which this strategic plan had been reported on, again NSW Government and other organisations were more positive (53% and 57% respectively) than individuals and their carers (33%); with health professionals and other individuals, again, somewhere in between (40%).

Figure 7: Level of agreement that the Commission *sufficiently monitored and reported on implementation of the Plan*, overall and by high level organisation and individual groupings (n=473)




### 1.5.1.3 Impact of the Strategic Plan

While respondents did not tend to be explicitly negative about the impacts of the strategic plan, there were few perceived positive effects. The most prevalent theme that emerged – in respondents own words - was that respondents had seen little impact on the mental health system or on the mental health and wellbeing of people of New South Wales, or that there had been some impact, but it was "not significant" or was "minimal" (15% of respondents).

The most frequently mentioned positive effect was associated with a perceived increase in general community awareness and consideration of mental health issues (14%), although the same proportion of respondents raised issues around insufficient funding or resourcing for mental health services (14%).

> *"Minimal impact. Although the Plan was solid and specific, the resources necessary to implement the Plan were not provided."* [NSW Health]

> *"It has provided a focus on individual mental health needs in the community."* [Peak body / representative non-government organisation]"
>
> *"Raised awareness in the community and government."* [Research/university sector]

NSW Government submissions were more likely than other respondents to express the view that the Commission's strategic plan had increased awareness of mental health issues (27%); while individuals with lived experience of mental illness were most likely to say that the impact had been negligible (21%).

> *"Created increased focus and attention. Assisted with raising the profile."* [Other NSW Government]
>
> *"Not much change that helps individuals and families."* [A person with lived experience of mental illness]

## 1.5.2 Reviewing, evaluating, reporting and advising on mental health services and programs

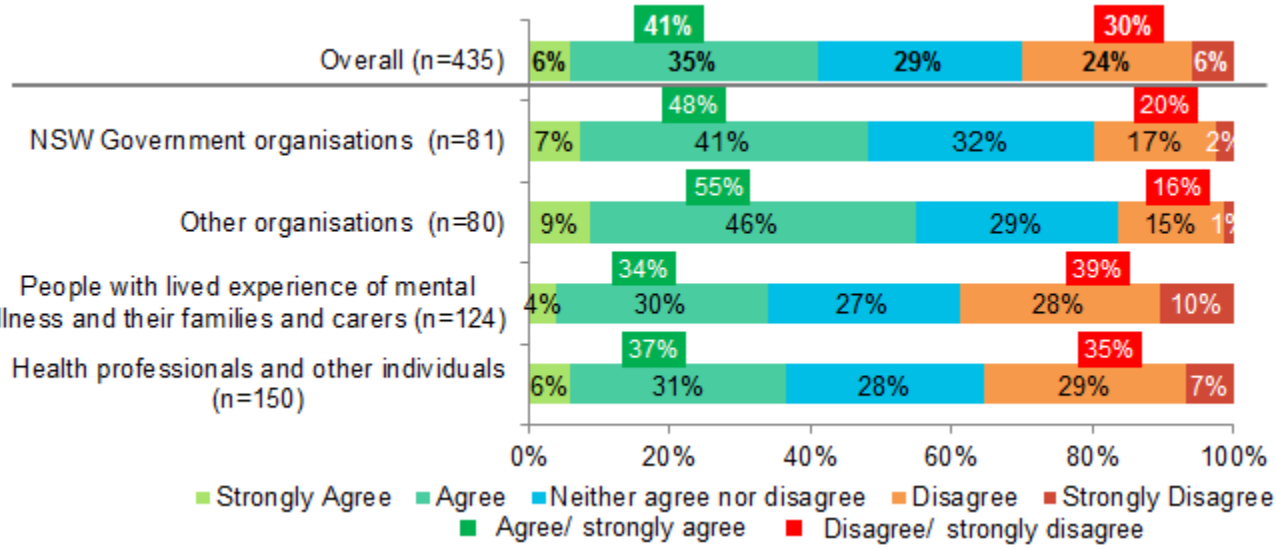
The third function defined by the Act was for the Mental Health Commission to *review and evaluate, and report and advise on, mental health services and other services and programs provided to people who have a mental illness, and other issues affecting people who have a mental illness*.

### 1.5.2.1 Reviewing and evaluating

Forty-one percent of respondents agreed/ strongly agreed that the Commission had effectively reviewed and evaluated mental health and other services, programs and issues (41%). NSW Government organisations and other organisations were the most likely to endorse this statement (48% and 55% respectively).

People with lived experience of mental illness and their carers (34%) and the remaining group of individuals (including health professionals) were less likely (37%) to endorse the Commission's review and evaluation work.

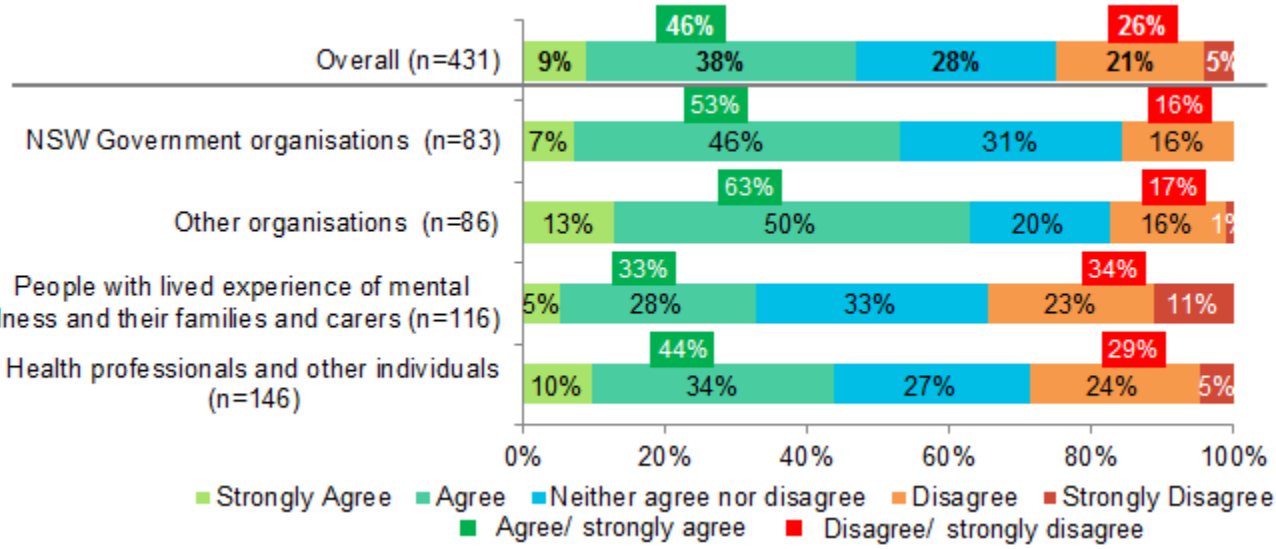
Figure 8: Level of agreement that the Commission effectively *reviewed and evaluated mental health and other services, programs and issues*, overall and by high level organisation and individual groupings (n=435)



### 1.5.2.2 Reporting and advising

Just under a half (46%) of submissions agreed/ strongly agreed that the Commission had effectively reported and advised on its review and evaluation work. The submissions from NSW Government and other organisations were less aligned than they were for most measures; with NSW Government being less positive on this occasion (53% compared with 63% of other organisations). Again, health professionals/other individuals tended to be less positive (44%) and people with lived experience and their families/carers less positive still (33%).

Figure 9: Level of agreement that the Commission effectively *reported and advised on mental health and other services, programs and issues*, overall and by high level organisation and individual groupings (n=431)




### 1.5.2.3 Significant achievements

As with the perceived impact of the strategic plan, respondents thought that heightened public and community awareness about mental health issues was the most positive outcome of the Commission's review and evaluation work, with about a fifth of respondents mentioning this (19%). Many also mentioned greater engagement with people with a lived experience of mental illness (17%), and increased consultation and engagement with carers, health care professionals and services and others, from all across the mental health sector (14%).

> *"Raising awareness of mental health issues."* [A family member or carer of a person with mental illness]
>
> *"The policy of the inclusion of consumers and carers in deciding treatment."* [A family member or carer of a person with mental illness]

*"Its ability to consult and work with stakeholders, as well to develop appropriate services for people with mental health and their family members."* [Other professional]

The Commission's most important achievement from the perspective of NSW Government (21%), and other organisations (26%), was raising public awareness; whereas the top priority according to people with lived experience of mental illness and their carers (22%), as well as other individuals (15%) was the Commission's engagement with consumers. The segment of individuals which included health professionals also highlighted the Commission's achievements in promoting and supporting the workforce in their top three.

*"Raising the profile of mental health in the community and addressing seclusion issues."* [Other NSW Government]

*"Inclusiveness of people with a mental health diagnosis in policy making."* [A person with lived experience of mental illness]

#### 1.5.2.4 Suggestions for more effectively focusing the Mental Health Commission's work

Many respondents (24%) were concerned with the lack of availability of services, or with the difficulty in timely access to services for individuals who needed them. They often cited resourcing issues as the cause of this.

*"Funding remains an issue … mental health is a huge issue for children, young people and their families. As well as medical/psychological interventions, practical supports would greatly assist …."* [Other NSW Government]

*"Sometimes there are not enough resources for people who are suffering and are turned away or misdiagnosed or just given a pill which does not work."* [A family member or carer of a person with mental illness]

The second most common suggestion for the Commission to consider was an enhanced focus on consumer (23%), and professional stakeholder (16%) engagement and consultation.

*"Get out and talk to the community to see what they want, not what the government wants to provide."* [Health professional]

*"There needs to be stronger engagement with primary health care, public hospitals - especially regional hospitals, with drug and alcohol services, and a focus on community and public health systems."* [Health professional]

*"More consultation with consumers and the health professionals who care for them."* [Health professional]

Consumer engagement was the top priority of individuals with lived experience and their carers (35%), followed closely by service accessibility (33%). The third priority for this segment was increased consumer rights (15%).

> *"Hands on approach. Listen and speak to families, carers and patients. Act on complaints; don't just sweep them under the mat!"* [A family member or carer of a person with mental illness]

> *"Introducing better access to services and reporting on best possible services that would meet individual needs."* [A family member or carer of a person with mental illness]

> *"[The Commission needs to] ensure that consumers have a say in what is happening and how service are delivered. Relying on an organisation's view is old fashioned and shuts down the voice of consumers. …."* [A person with lived experience of mental illness]

The top suggestion from submissions within NSW Government organisations was that the Commission should focus on standardised objectives and outcome frameworks in order to enhance its accountability (32%).

> *"Write clearly and set out clear objectives, rather than writing in vague terms and promoting yet more bureaucracy."* [NSW Health]

## 1.5.3 Knowledge sharing

The fourth function outlined by the Act was for the Mental Health Commission to *promote and facilitate the sharing of knowledge and ideas about mental health issues.*

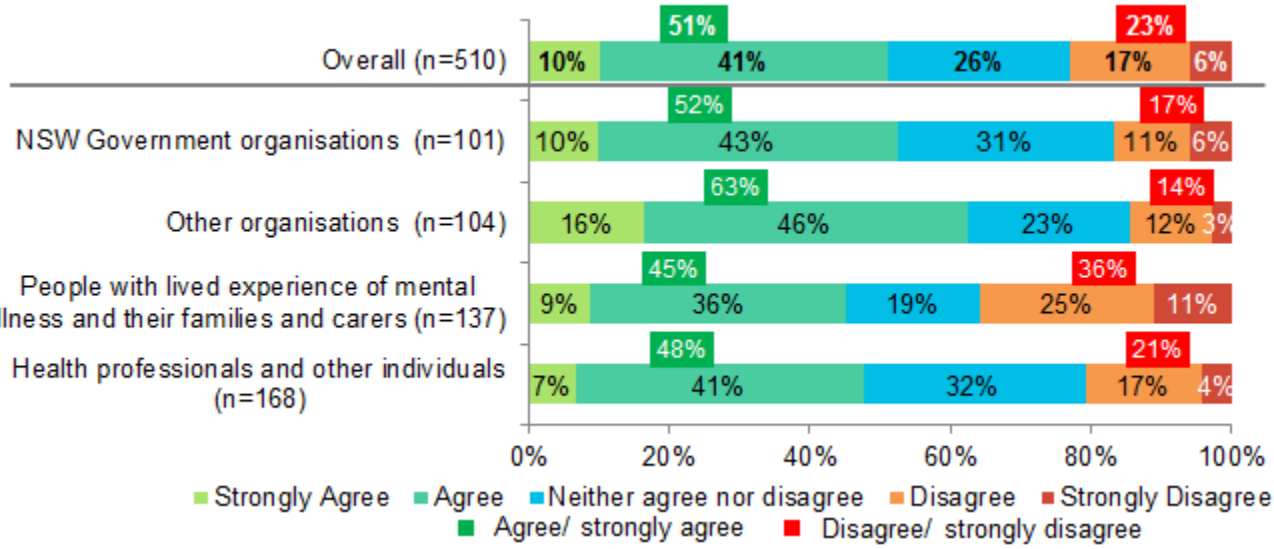
### 1.5.3.1 The promotion and facilitation of knowledge sharing about mental health issues

Overall, half of respondents (51%) agreed/ strongly agreed that the Commission had promoted and facilitated knowledge sharing about mental health issues in an effective way.

Those with lived experience of mental illness/their carers were the least positive (45%), with health professionals/other individuals showing similar levels of agreement (48%).

The most positive result (63%) came from 'other' organisations (i.e. not pertaining to NSW Government).

Figure 10: Level of agreement that the Commission *promoted and facilitated knowledge sharing about mental health issues in an effective way*, overall and by high level organisation and individual groupings (n=510)




### 1.5.3.2 Suggestions for further promotion and facilitation of the sharing of knowledge

Consultation respondents believed that increased consumer engagement, the provision of more educational information (including through conferences, publications, mobile phone

apps, social media, or videos, for example), and additional stakeholder consultation were the most common suggestions (each of these were mentioned by 21% of overall respondents).

> *"Consult with users, not NGOs."* [A person with lived experience of mental illness]
>
> *"More use of social media and traditional media."* [Peak body / representative non-government organisation]
>
> *"The MHC needs to engage with better with LHDs and clinicians."* [Health professional]

Increased user engagement, in the context of knowledge sharing, was the top suggestion of people with a mental health condition and their carers (33%). This was followed by use of the media (20%) and dissemination via publications and forums (17%).

> *"Work more with families and carers. LISTEN MORE!"* [A family member or carer of a person with mental illness]
>
> *"Make this known via media outlets - TV, radio, news media, online, through CHSP service providers"* [A person with lived experience of mental illness]
>
> *"Online marketing. Email to all community services organisations. Face to face presentations to the public at local community based halls/centres."* [A person with lived experience of mental illness]

NSW Government responses also highlighted the media (27%) and publications and forums (27%), and they also put wider collaboration with NGOs and private providers in their top three (15%).

> *"Advertise more widely. I'm not familiar with the work of the MHC."* [NSW Health]
>
> *"Events that promote the sharing of mental health issues have not been widely visible."* [NSW Health]
>
> *"Get out there and talk with teams of services across the state."* [NSW Health]

#### 1.5.3.3 Examples of the Mental Health Commission's promotion and facilitation of knowledge sharing

A fifth of respondents expressed, in their own words, positive sentiments about with the meetings, conference, workshops and presentations that the Commission had initiated (20%).

> *"Collaborative and effective meetings around suicide prevention across sectors as diverse as police, ambulance, [people with] lived experience, primary health care networks, etc."* [Other]

> *"The Commission is very visible as an actor at events and meetings and does not just listen, but creates new knowledge through discussions and opinions."* [Research/university sector]

A fifth also commended the Commission on its papers and other publications, including those that it had made publicly accessible on its website (19%).

> *"Publications that are available online and have been discussed at various meetings."* [A family member or carer of a person with mental illness]
>
> *"I have found the emails informative."* [Health professional]
>
> *"Its website has information on mental health and CALD communities."* [NSW Health]

Individuals from both segments were most likely to highlight the effectiveness of publicly available information and resources (25%); as were submissions from NSW Government (23%).

> *"Availability of the strategic plan brochure in waiting rooms at community mental health centres."* [A person with lived experience of mental illness]
>
> "*Physical health and mental wellbeing: an evidence guide."* [NSW Health]

NSW Government respondents also felt that the Commission had been successful in the development of other specific programmes or strategies, and the incorporation of lived experience (both 13%).

> *"I can recall a strategic direction in relation to treating people with trauma. I think that was a useful and sensible direction and acknowledgement."* [NSW Health]
>
> *"GSC was engaged in the International Cities Collaborative for Mental Health (I-Circle) through the Mental Health Commission in 2017."* [Other NSW Government]
>
> *"I have been in meetings where they have represented the needs of people with lived experience in a way which advocated and raised awareness."* [NSW Health]

## 1.5.4 Research, innovation and policy development

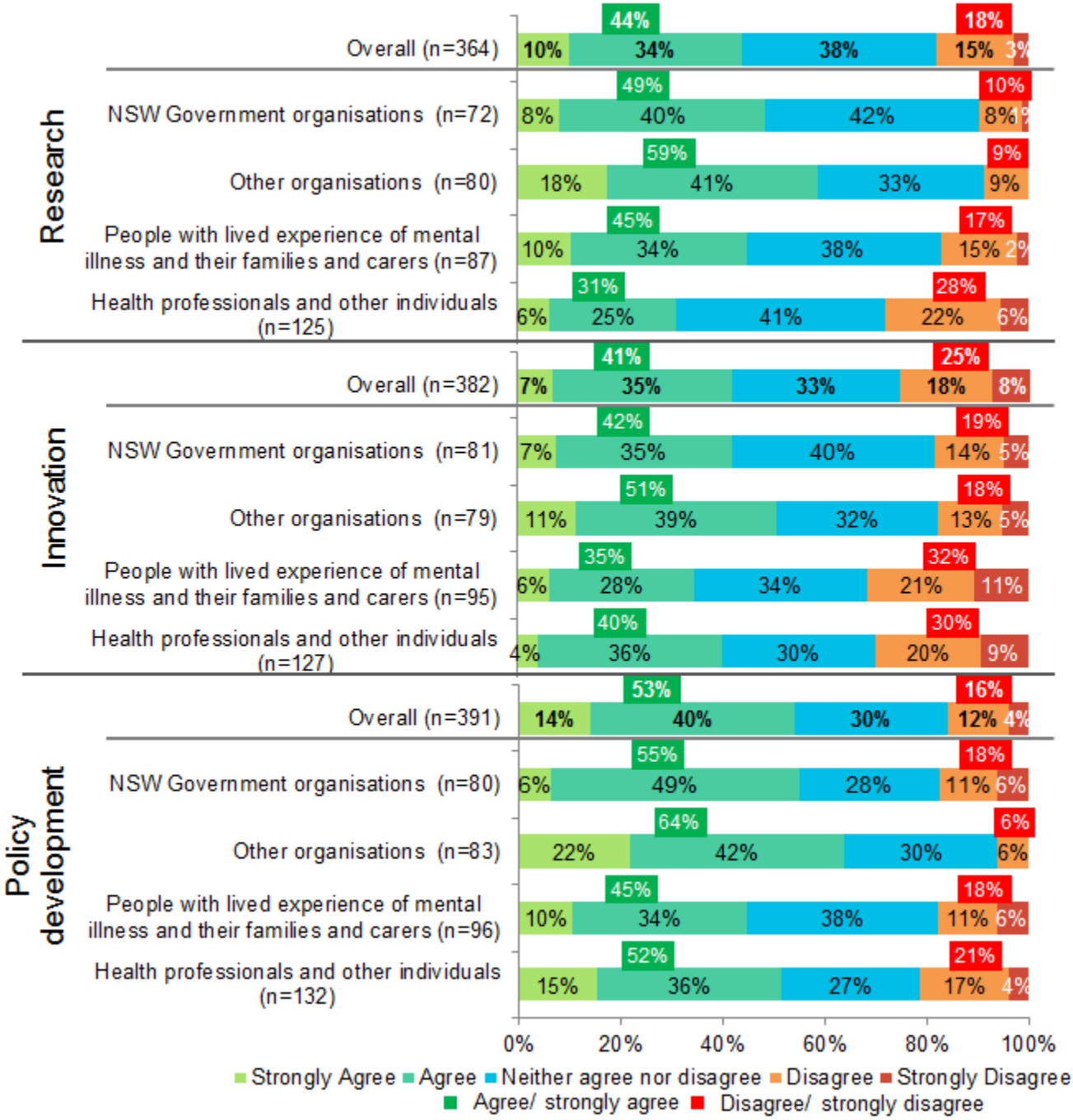
Under the Act, the Mental Health Commission's fifth function was to *undertake and commission research, innovation and policy development in relation to mental health issues*.

### 1.5.4.1 Research, innovation and policy development

Overall, 44% of respondents agreed/ strongly agreed that the Commission had undertaken research effectively; and 41% agreed/ strongly agreed that it had undertaken innovation effectively. Respondents were generally more positive about the Commission's policy development work, with more than half agreeing/ strongly agreeing with its effectiveness in this function area (53%).

The pattern of findings was similar across these three attitude statements. People with lived experience and their carers were the least positive; submissions from NSW government and other organisations were the most positive. The remaining group of individuals (including health professionals) tended to fall somewhere in between the two. Of note, the only exception to this was that health professionals/other individuals were the least likely to feel that the Commission had been effective in its research (31% - compared with 44% overall).

Figure 11: Level of agreement that the Commission effectively undertook *research, innovation, and policy development*, overall and by high level organisation and individual groupings (n=391)



### 1.5.4.2 The impact of the Mental Health Commission's research, innovation, policy development and education initiatives

A fifth of respondents believed that there had been little concrete impact on service provision, nor that there was any evidence of direct effects on individuals (20%).

> *"It is not widely known, therefore very little."* [A family member or carer of a person with mental illness]
>
> *"I can't think of any I would attach specifically to the Commission; it's pretty invisible."* [Health professional]
>
> *"That's the problem, I can't think of one."* [A family member or carer of a person with mental illness]

However, 15% were positive about the policy focus on community engagement and person-centred care, and the widening of health care approaches to allow an "open dialogue" which considers the views of the person with mental illness, as well as their families and carers, and concentrates on care and recovery, rather than simply "custodial care" for mentally ill people.

> *"Engagement of people with lived experience of mental health to guide current and future service objectives."* [Mental health service provider or non-government organisation]

Many respondents also spoke positively about many of the Commission's communications activities, including its brochures, reports and other research and educations materials and the media campaigns to raise awareness of issues in the wider community (11%).

> *"Mental Health month campaigns."* [Other NSW Government]
>
> *"The videos produced this year by the Commission and two partner organisations were great."* [Mental health service provider or non-government organisation]
>
> *"I thought the report on medications was really good and had the voices of consumers in it."* [A person with lived experience of mental illness]

People with lived experience of mental illness/carers were most likely to articulate negative comments (31%) and to positively discuss communications aimed at raising public awareness (23%).

> *"I do not think there has been sufficient research, innovation or policy development. If there was, surely some of the emergency services, paid and volunteer, would have been involved."* [A person with lived experience of mental illness]

*"Their website says they do [have an impact], but none of it seems to make any difference to the way individuals and families are treated and the lack of stable funding so workers and programs stay available."* [A person with lived experience of mental illness]

*"Education initiatives, like they were at the Easter Show. Their reports can have a positive impact on the sector at driving change."* [A person with lived experience of mental illness]

*"Television advertisement and education."* [A person with lived experience of mental illness]

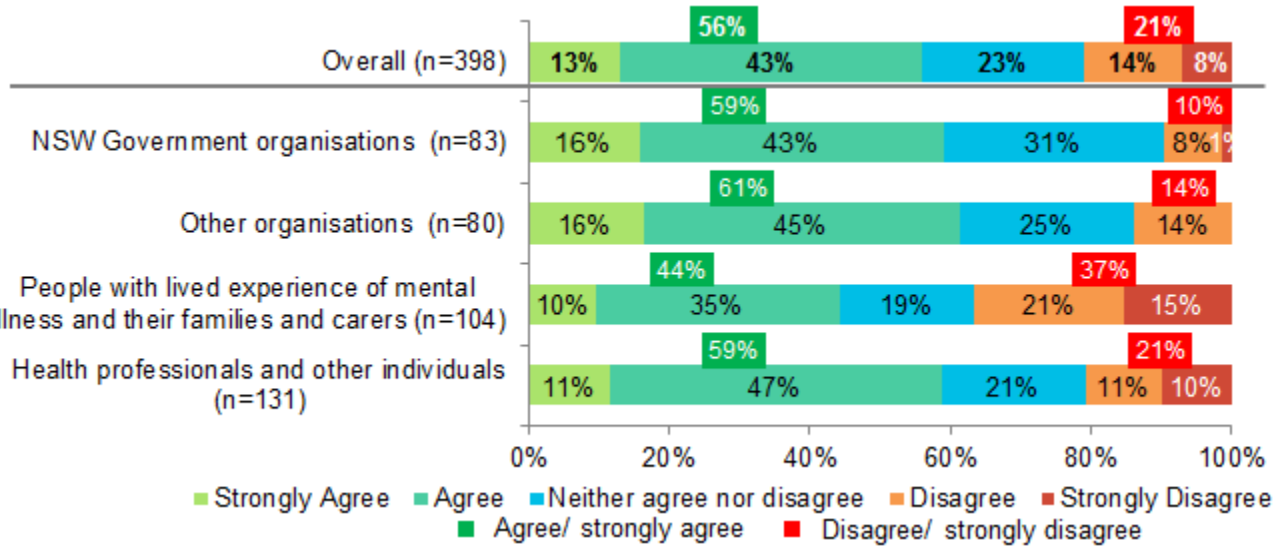
## 1.5.5 Education

The Mental Health Commission's eighth function, under the Act, was to *educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness.*

### 1.5.5.1 Education initiatives

Respondents were asked whether they agreed or disagreed that the Mental Health Commission had effectively undertaken initiatives to educate the community about mental health issues (including to reduce the stigma and discrimination). Over half agreed/ strongly agreed that it had (56%). Levels of agreement were similar across the major segments shown in Figure 65, with the exception that people with lived experience and carers were less positive (44%) regarding the Commission's work in educating the community.

Figure 12: Level of agreement that the Commission effectively undertook *initiatives to educate the community about mental health issues*, overall and by high level organisation and individual groupings (n=398)



#### 1.5.5.2 The impact of the Mental Health Commission's education initiatives

One in ten respondents mentioned the Commission's public awareness campaigns as examples of education initiatives which had a positive impact on the mental health and wellbeing of the people of New South Wales. These included:

- Check up from the Neck-up (when taken out into the community)
- R U OK?
- Project Air Strategy for Schools

One of the most important outcomes of education initiatives was perceived to be the reduction of mental illness stigma in society, which was mentioned by 4% of respondents.

### 1.5.6 Advocacy

The Act included two advocacy and promotion functions for the Mental Health Commission (the sixth and seventh functions). These were to *advocate for and promote*:

- *the prevention of mental illness and early intervention strategies for mental health*
- *the general health and well-being of people who have a mental illness and their families and carers*.

#### 1.5.6.1 Advocacy and promotion functions

Respondents thought that the Commission had had performed better in advocating and promoting the general health and wellbeing of people with a mental illness and their families (53% agreed/ strongly agreed), than at advocating and promoting the prevention of mental illness and early intervention strategies (43% agreed/ strongly agreed).

A familiar pattern of results emerged across both statements, with higher levels of agreement among NSW Government and other organisations (58% and 52% respectively), than among individuals with lived experience/carers (32%); and those of health professionals/other individuals falling somewhere between the two (38%).

Figure 13: Level of agreement that the Commission effectively fulfilled its functions to advocate for and promote *the prevention of mental illness and early intervention strategies for mental health*, overall and by high level organisation and individual groupings (n=390)

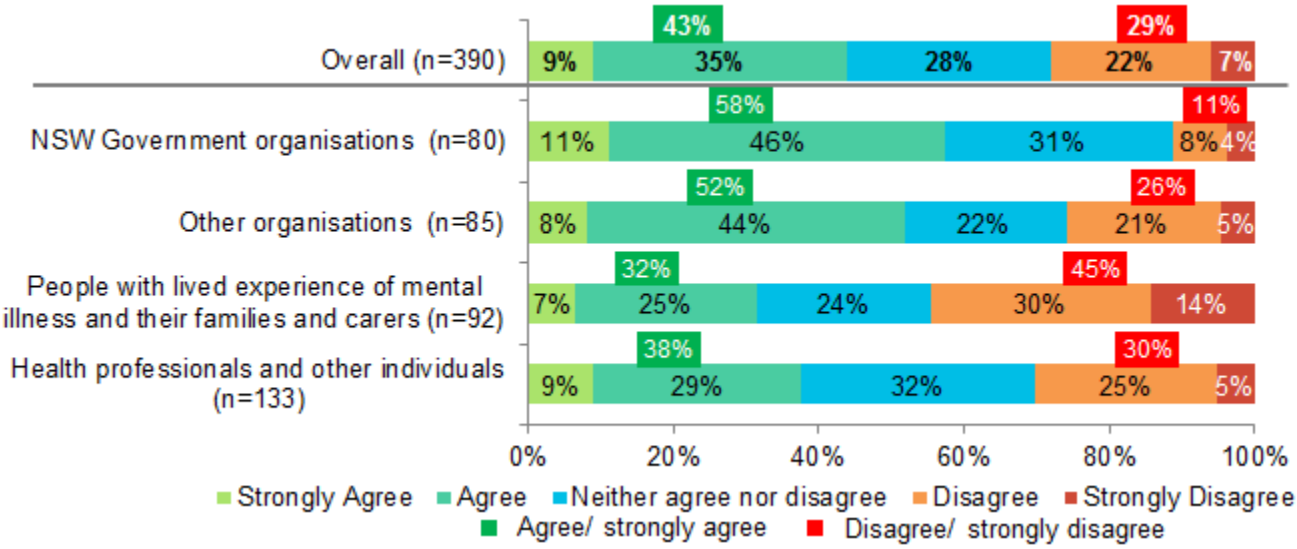
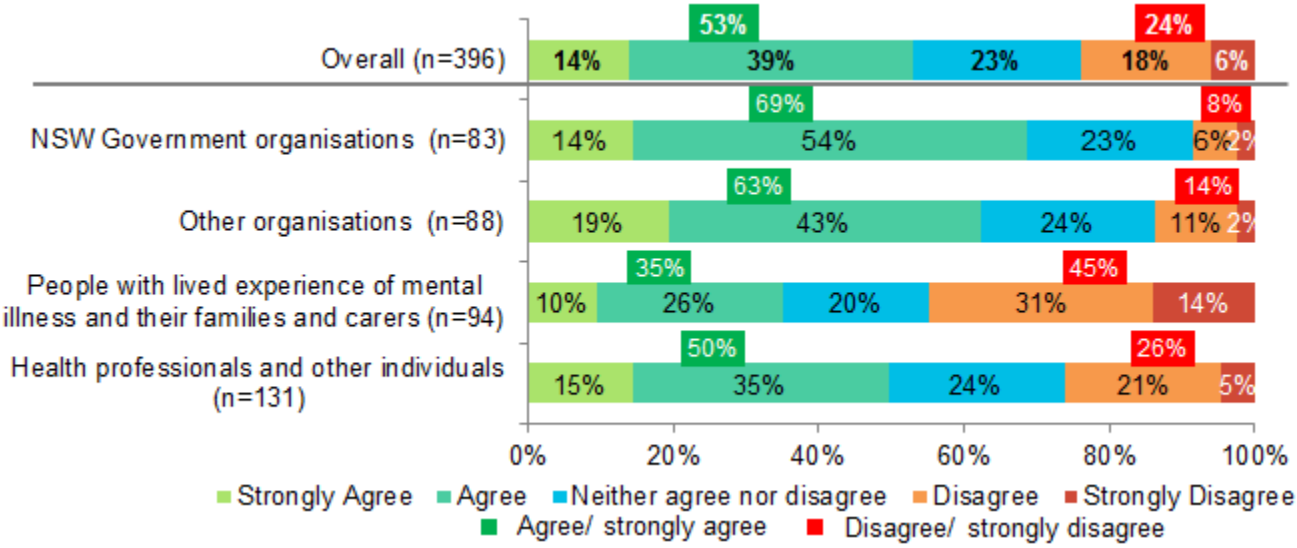



Figure 14: Level of agreement that the Commission effectively fulfilled its functions to advocate for and promote *the general health and wellbeing of people who have a mental illness and their families*, overall and by high level organisation and individual groupings (n=396)



### 1.5.6.2 The impacts of the Mental Health Commission's advocacy and promotion activities

A third of respondents thought that the Commission's advocacy and promotion activities had resulted in greater awareness and understanding of mental illness in the general community (31%).

> *"Raising the level of awareness and giving people a voice."* [NSW Health]
>
> *"Improved awareness; reduction in stigma."* [Mental health service provider or non-government organisation]

However, 28% thought there was little evidence of any impact, or said that they had not noticed any advocacy or promotion activities, and 12% took the opportunity to voice concerns about the mental health sector in general, or the Commission's or Government's role and limited impact beyond advocacy and promotion activities.

> *"Very little actual impact."* [Health professional]
>
> *"None that I have noticed."* [A family member or carer of a person with mental illness]
>
> *"The information promotions activities have helped in raising awareness, but the very limited resources at the front line of the tertiary mental health services remain woefully inadequate to implement all recommendations."* [Health professional]
>
> *"It wasn't really supported at all levels. You can promote all you like, but if systems don't change and this isn't supported by government at all levels, nothing changes."* [Health professional]

Submissions from NSW Government were markedly more likely than the other segments to express that the Commission's promotion activities had resulted in greater awareness of mental illness (60%, compared with only 18% of individuals with lived experience or their carers). The latter were correspondingly more likely, along with the other individuals and health professionals, to articulate negative response to this question.

> *"Stigma reduction and awareness raising."* [Other NSW Government]
>
> *"It has shone more light on the issues and brought them more into focus for general community."* [NSW Health]

## 1.6 The Ministerial Charter letter of 2016

Respondents were asked about the Commission's effectiveness in meeting two of the priorities from the Ministerial Charter letter of 2016:

- to *continue to work closely with the NSW Government and Commonwealth agencies to ensure the NDIS takes appropriate account of the needs of people with psychosocial disability as a consequence of mental illness*
- to *further develop innovative responses to the mental health and wellbeing needs of young people, noting their particular patterns of distress, service access preferences and help-seeking behaviours*.

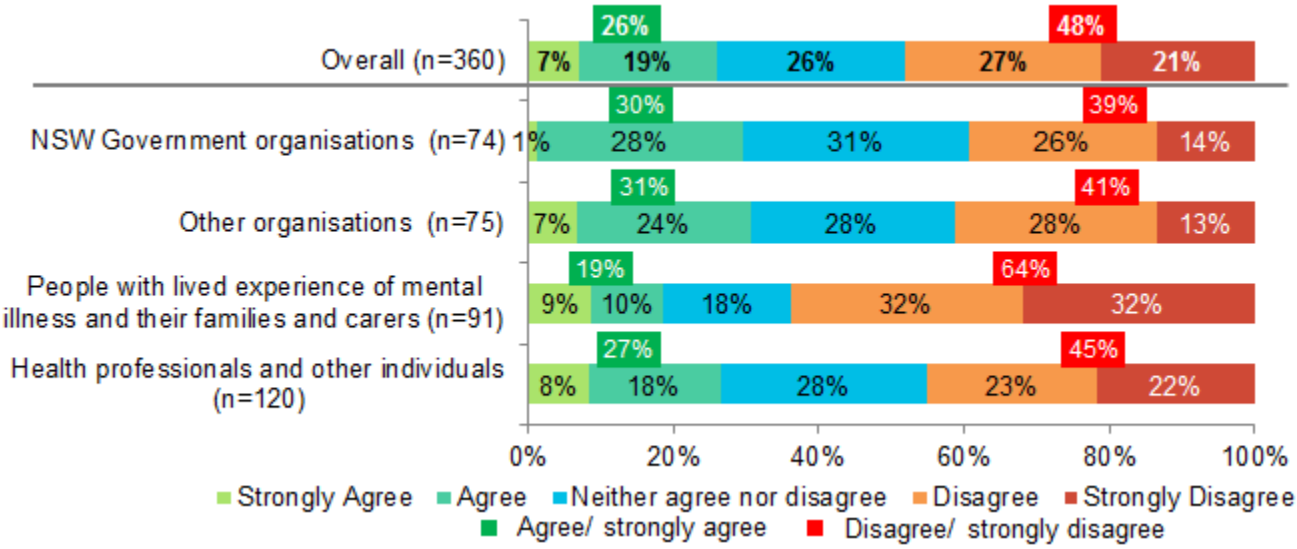
Compared with the results for the Commission having been effective in carrying out most of its functions, the overall agreement to its having been effective these two priority areas was low.

### 1.6.1 NDIS

Only a quarter (26%) of submissions indicated broad agreement the Commission had effectively ensured that the NDIS takes account of the needs of people with a psychosocial disability as a consequence of mental illness, with almost a half (48%) broadly disagreeing with this premise. The remaining quarter (26%) were neutral.

Levels of agreement ranged from 19% of people with lived experience/their carers to 30% of NSW Government and 31% of other organisations. Just over a quarter (27%) of the group comprising health professionals and other individuals agreed with this statement.

Figure 15: Level of agreement that the Commission effectively *ensured that the NDIS take appropriate account of the needs of people with psychosocial disability as a consequence of mental illness*, overall and by high level organisation and individual groupings (n=360)



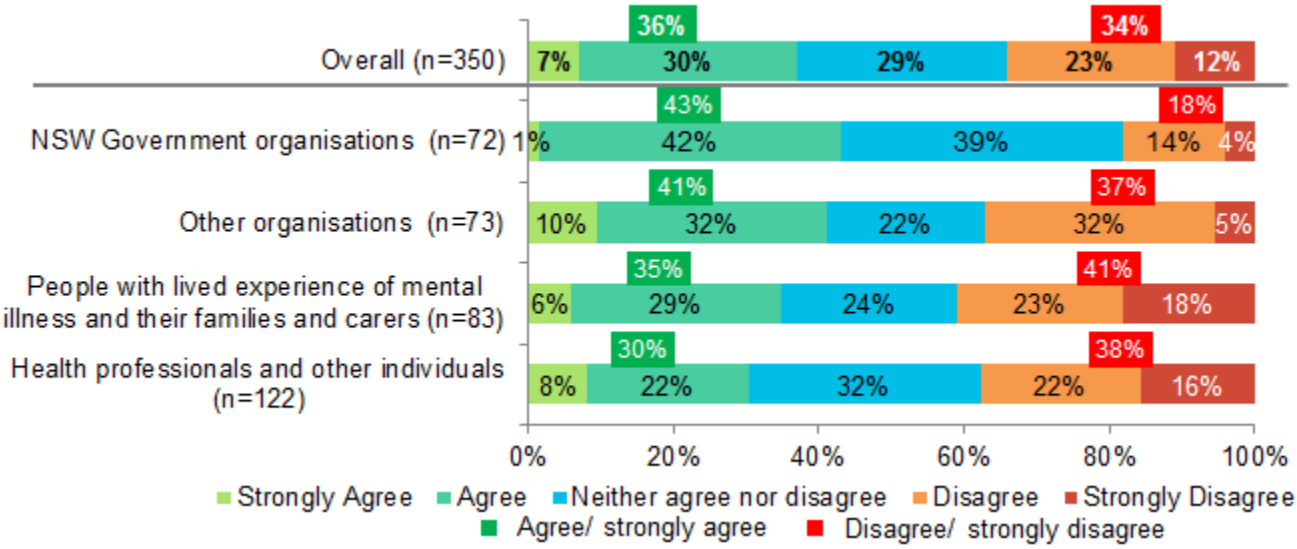
## 1.6.2 Young people

Unfortunately, young people did not provide their views on the Commission's responses to their particular needs; however, health professionals gave this area of the Commission's work an uncharacteristically low rating.

Just over a third of submissions (36%) that the Commission had developed innovative responses to the particular mental health needs of young people, while just under a third (34%) disagreed/ strongly disagreed.

Organisations forming part of NSW Government (43%) and other organisations (41%) were the most likely to endorse this statement; while non-consumer individuals (including health professionals) were the least likely (30%). Just over a third (35%) of people with lived experience of mental illness and their carers felt that the Commission had effectively responded to the needs of young people.

Figure 16: Level of agreement that the Commission effectively *developed innovative responses to the particular mental health and wellbeing needs of young people*, overall and by high level organisation and individual groupings (n=350)



## 1.7 Operations – The exercising of the Commission's functions

In section 3.12.2, The Act listed a number of ways the Mental Health Commission was to exercise its functions, as also defined under the Act. Overall positivity in these measures ranged from 37% to 58% of respondents.

The highest proportions of respondents agreed/ strongly agreed that the Commission had:

- focused on system wide mental health issues (58%)
- effectively engaged and consulted with NSW Government (58%)
- effectively engaged and consulted with families and carers of people with a lived experience of mental illness (55%).

While organisations were more likely than individuals to be positive about the Commission's engagement and consultation with them (NSW Government and non-government sector organisations), people who had experienced mental illness themselves and their families and carers were markedly less likely to agree that that the Commission had effectively engaged and consulted with them.

Sixty percent of people with lived experience disagreed/ strongly disagreed that the Commission's efforts to engage and consult with them had been effective (60%), and 51% of families and carers disagreed/ strongly disagreed that the Commission's efforts with them had been effective.

The measures with the lowest levels of positivity, from respondents overall, were: engagement and consultation with *the whole community* (37%), and having taken into account the interaction between people who have a mental illness and the criminal justice system (43%).

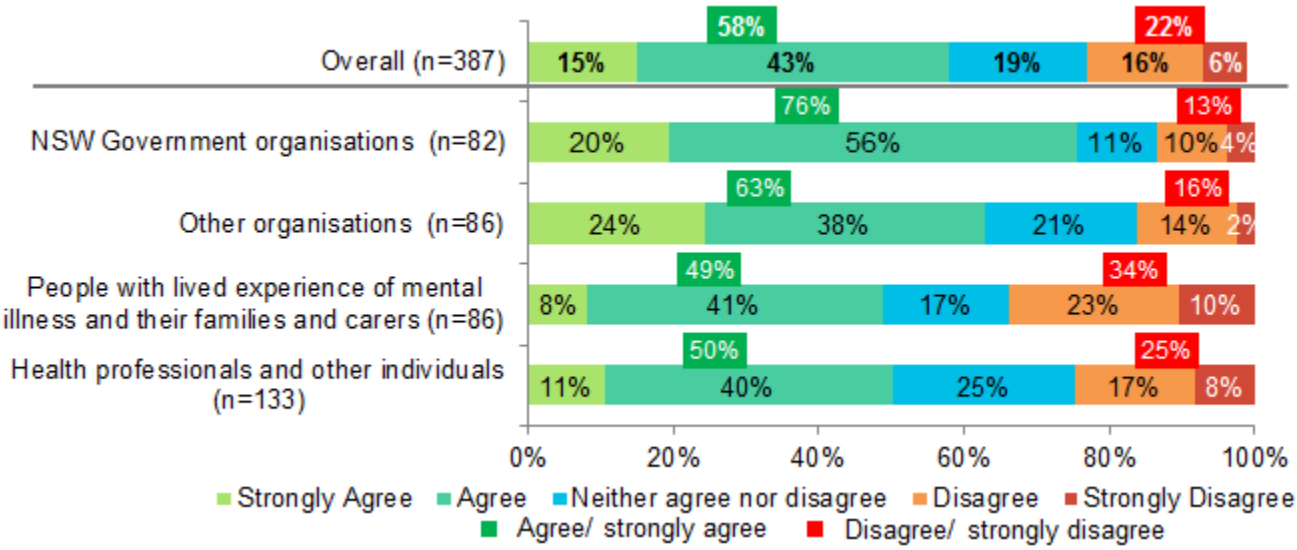
## 1.7.1 System-wide focus

The Act required the Commission to *focus on systemic mental health issues*.

### 1.7.1.1 Focus on system-wide mental health issues

There was a good deal of variation in levels of agreement in the extent to which the Commission's work has focused on system wide mental health. People with mental illness and their carers (49%) and also health professionals/other individuals (50%) had relatively low levels of endorsement. Submissions from the NSW Government were the most positive (76%).

Figure 17: Level of agreement that the Commission's work has *focused on system wide mental health issues*, overall and by high level organisation and individual groupings (n=387)




### 1.7.1.2 The impact of the Mental Health Commission's system-wide focus

A third of respondents thought that the Commission had not focused on system-wide issues, or that its focus had been "piecemeal", with "lots of words on paper, lots of nice documents - little action and no change on the ground" (34%).

> *"System-wide issues are addressed in the strategic plan and the 'One year on' report, but I can't see a link between that and people's lives."* [Other NSW Government]
>
> *"It hasn't successfully focused, except by funding NGOs, who do nothing."* [A person with lived experience of mental illness]

When respondents were positive about the impacts, it was most often about there now being a greater focus, in the sector, on the needs of consumers and support provision for people with mental illness and their families and carers (17%), and about better collaboration between all the various agencies (15%).

> *"The Commission has started the transition towards true partnership and collaboration with people who have a lived experience of mental illness."* [Health professional]
>
> *"I think each health district may be different, but in our area, a focus on youth mental health has been evident and has included the health and community sectors."* [Other not-for-profit organisation]
>
> *"Through its emphasis on consultation with people who have mental health issues, carers and professionals, the Commission has effectively united the efforts of disparate groups. However, the NSW State Government has not responded with suitable funding arrangements and thus the Commission's recommendations have had limited real impact on the sector to date."* [A family member or carer of a person with mental illness]

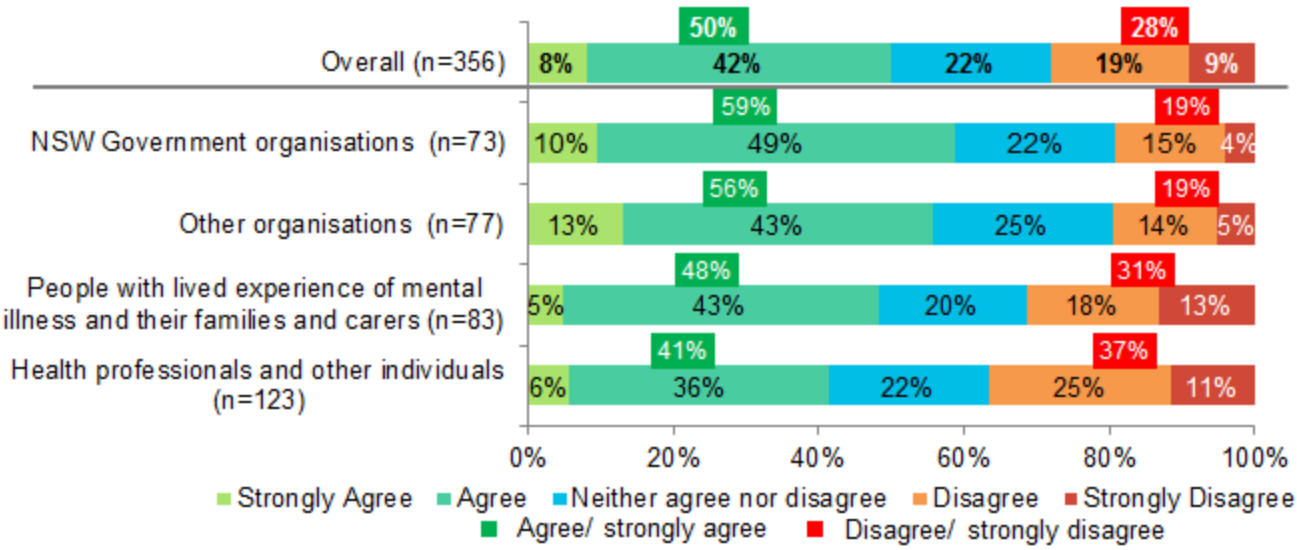
## 1.7.2 Co-morbidity issues

The Commission was required, under the Act, *to take into account co-morbid issues associated with mental illness, such as drug and alcohol use and disability.*

A half (50%) of submissions agreed that the Commission's work had met the objective of taking into account co-morbidity issues. Just over a quarter (28%) disagreed while just under a quarter remained neutral.

Again, the two least positive segments comprised health professionals/other individuals (41% agreed/strongly agreed) and people with lived experience of mental illness and their carers (48%). This compared with 59% of submissions from NSW Government and 56% of other organisations.

Figure 18: Level of agreement that the Commission's work has taken into account *co-morbidity (e.g. drug and alcohol, disability),* overall and by high level organisation and individual groupings (n=356)



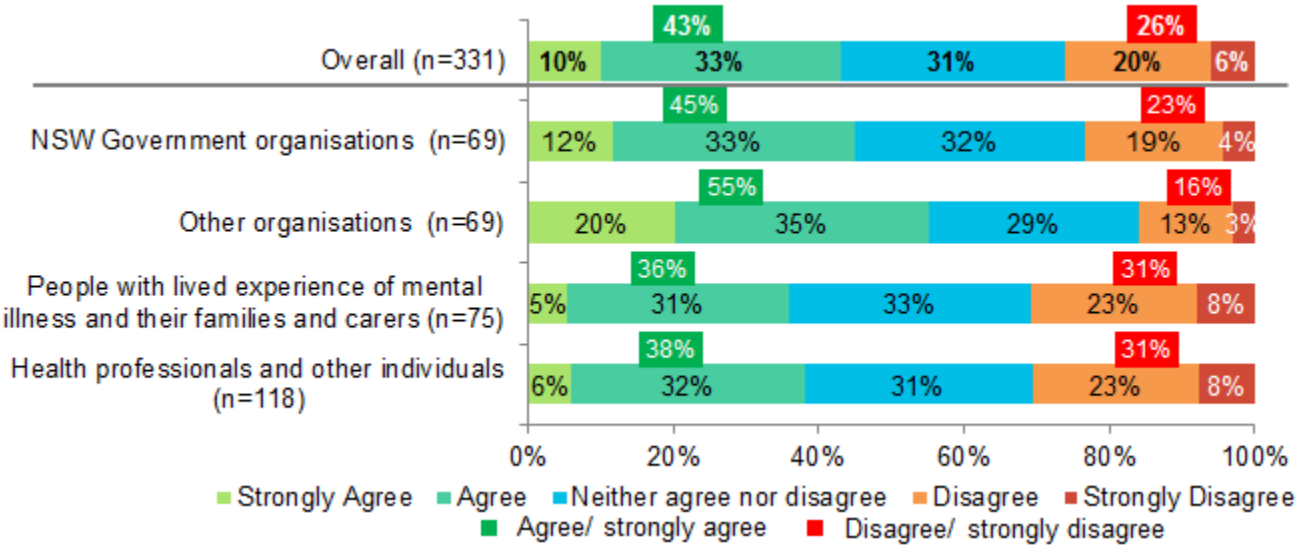
### 1.7.3 People who have a mental illness, and the criminal justice system

Another requirement under the Act, was for the Commission *to take into account issues related to the interaction between people who have a mental illness and the criminal justice system*.

Levels of agreement were quite low in relation to this measure; with 43% agreeing (strongly agree/agree), 26% disagreeing (disagree/strongly disagree), and 31% indicating that they neither agreed nor disagreed (perhaps indicating a lack of knowledge/awareness of how the Commission is performing in this regard.

The familiar pattern emerged, with NSW Government and other organisations being most likely to endorse the work of the Commission (45% and 55% respectively); and individuals with lived experience of mental illness and their carers (36%) and the group of health professionals/other individuals (38%) being least positive.

Figure 19: Level of agreement that the Commission's work has taken into account *the interaction between people who have a mental illness and the criminal justice system,* overall and by high level organisation and individual groupings (n=331)



### 1.7.4 Different sections of the community

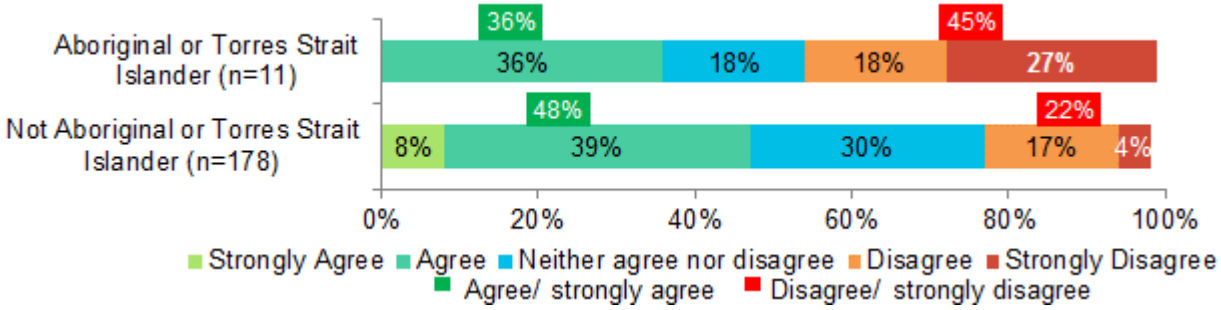
The Act stated that, in exercising its functions, the Commission was *to take into account the particular views and needs of different sections of the community, including Aboriginal communities, culturally and linguistically diverse communities and regional and remote communities*.

Overall, around one in two respondents agreed with each of the statements.

There was a consistent pattern of lower endorsement among individuals (including those with lived experience of mental illness/carers and health professionals); and higher positivity among NSW Government and other organisations, as shown in Figure 23.

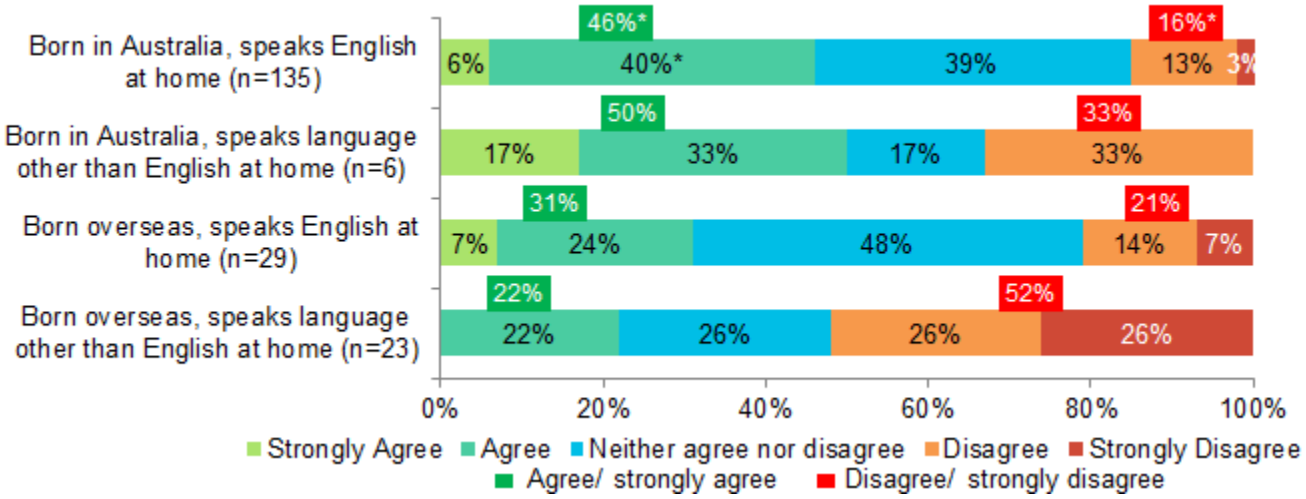
Just over half (53%) of all submissions agreed/strongly agreed with the statement that the Commission's work takes into account the needs of Aboriginal Australians. Aboriginal Australians were less likely to agree with this statement (36% compared with 48%).

Figure 20: Level of agreement that the Commission's work has taken into account the needs of *Aboriginal people and communities*, by high Aboriginal and Torres Strait Islander origin (n=189)



Just under a half (48%) of submissions felt that the needs of CALD communities are met by the Commission's work. Those born overseas were the least positive in this regard, irrespective of whether they spoke English or a language other than English at home (31% and 22% respectively).

Figure 21: Level of agreement that the Commission's work has taken into account the needs of *culturally and linguistically diverse communities* by culturally and linguistically diverse categories (n=193)




Agreement with success in meeting the needs of regional and remote communities was slightly lower overall (47%) than the communities discussed above; and was notably lower among those from inner regional (36%) and remote (31%) communities themselves, compared with city dwellers (51%).

Figure 22: Level of agreement that the Commission's work has taken into account the needs of *regional and remote communities,* by remoteness categories (n=349)

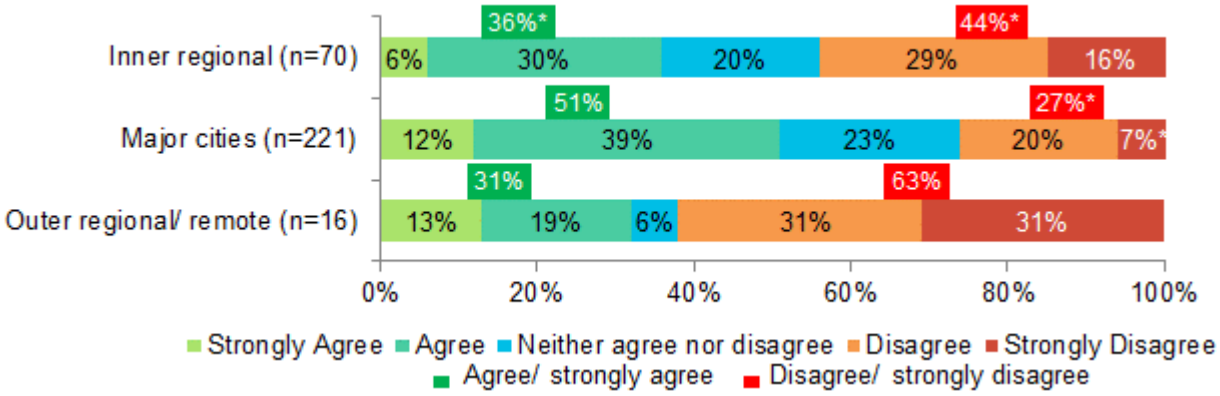
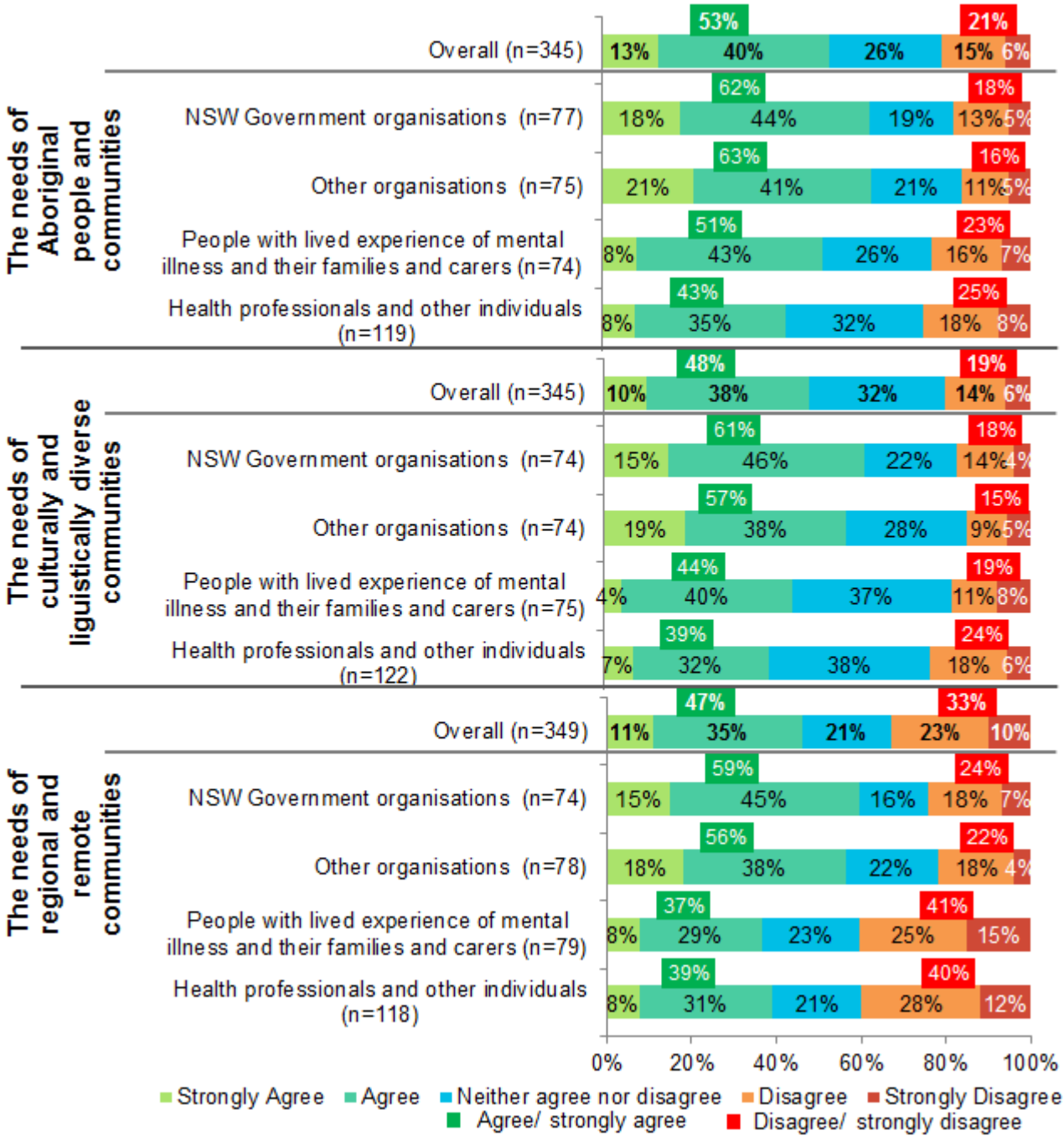


Figure 23: Level of agreement that the Commission's work has taken into account the needs of *Aboriginal people and communities, culturally and linguistically diverse communities, and regional and remote communities*, overall and by high level organisation and individual groupings (n=349)



### 1.7.5 Engagement and consultation

The Act also required the Commission to *engage and consult with*:

- *people who have a mental illness and their families and carers*
- *the government and non-government sectors*
- *the whole community.*

#### 1.7.5.1 People who have a mental illness and their families and carers

Around half of submissions agreed/strongly agreed that the Commission's work had effectively engaged and consulted with people with a mental illness (52%). Three in ten (29%) disagreed/ strongly disagreed with this statement, and one fifth (19%) were neutral.

People who had experienced mental illness themselves and their carers were markedly less likely to agree that the Commission had effectively engaged and consulted with them (35%). Looking separately at individuals and carers showed that individuals were less likely to agree/ strongly agree that they had been engaged with (29%) than their carers/families (41%).

A similar proportion overall (55%) endorsed the Commission's work in engaging with the families and carers of people with a mental illness. Again, positivity was lower among the target segment itself (40%) than among NSW Government (67%) and other organisations (65%). This time, the pattern within the individuals category was reversed, with 37% of carers/family members feeling that they had been effectively consulted, compared with 44% of those with lived experience of mental illness.

Figure 24: Level of agreement that the Commission has effectively engaged and consulted with *people who have a mental illness, and families and carers of people with a lived experience of mental illness*, overall and by high level organisation and individual groupings (n=365)

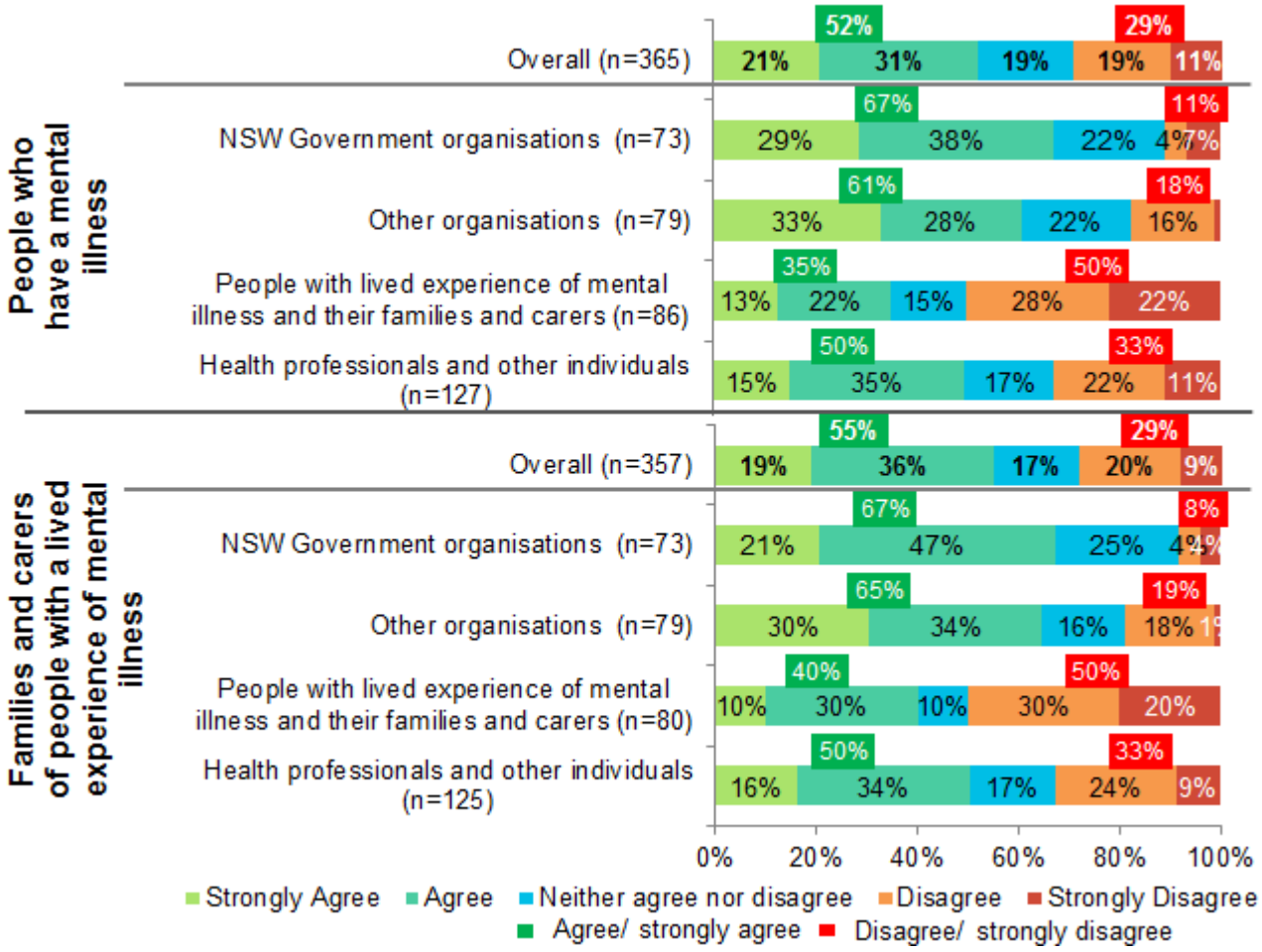
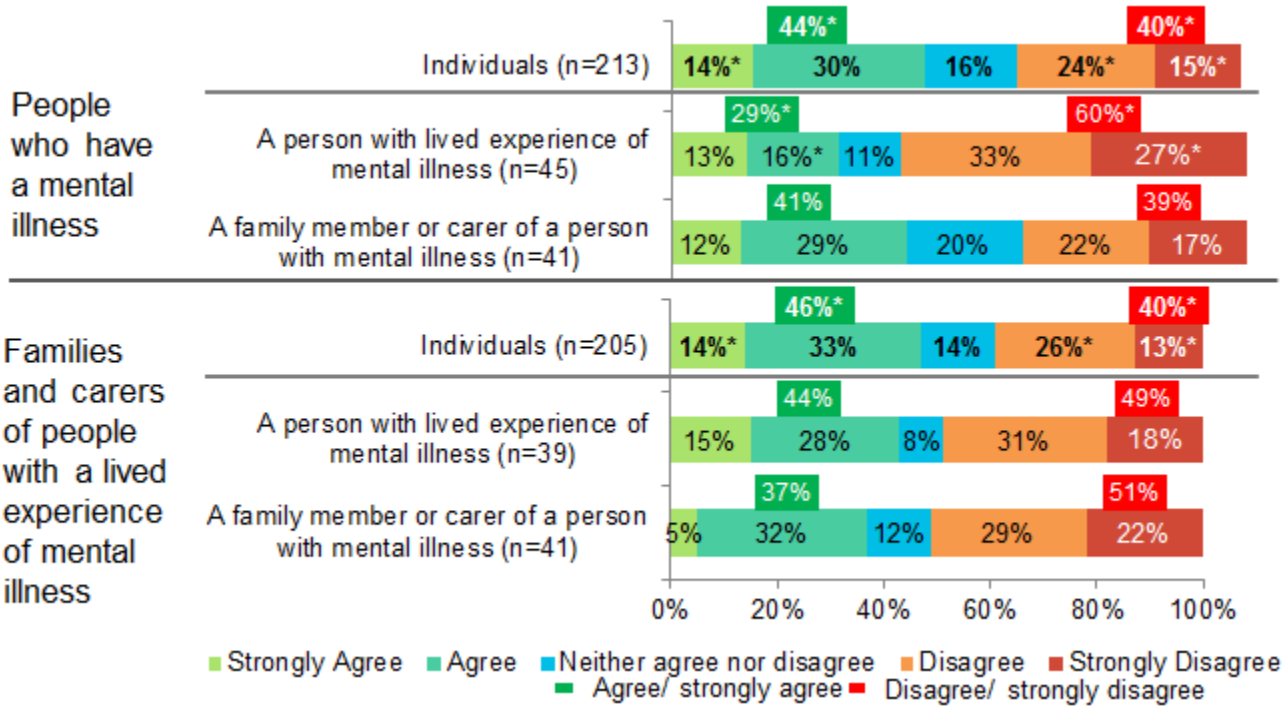


Figure 25: Level of agreement that the Commission has effectively engaged and consulted with *people who have a mental illness, and families and carers of people with a lived experience of mental illness*, by individuals overall, by consumers, and by families and carers (n=213)

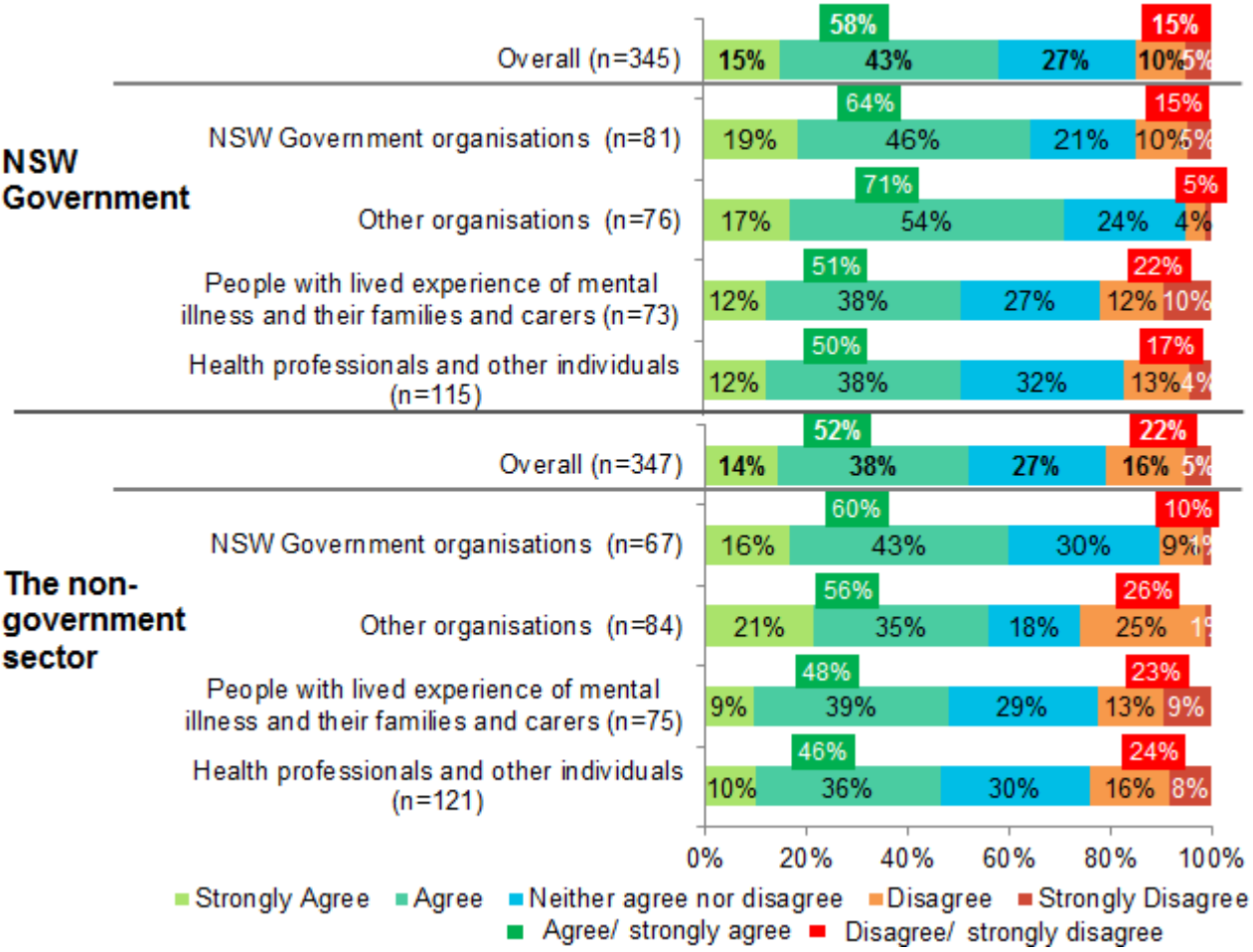


### 1.7.5.2 The government and non-government sectors

The consultation also covered aspects of the Commission's engagement with the government and non-government sectors in NSW. The majority of submissions agreed/strongly agreed that the Commission had engaged effectively with both the government (58%) and the non-government sectors (52%).

Levels of endorsement were high among the target segments themselves, with 64% of NSW Government organisations agreeing/strongly agreeing that they had been effectively engaged with; and 56% of non-NSW Government organisations endorsing their relevant statement.

Figure 26: Level of agreement that the Commission has effectively engaged and consulted with *NSW Government, and the non-government sector*, overall and by high level organisation and individual groupings (n=347)

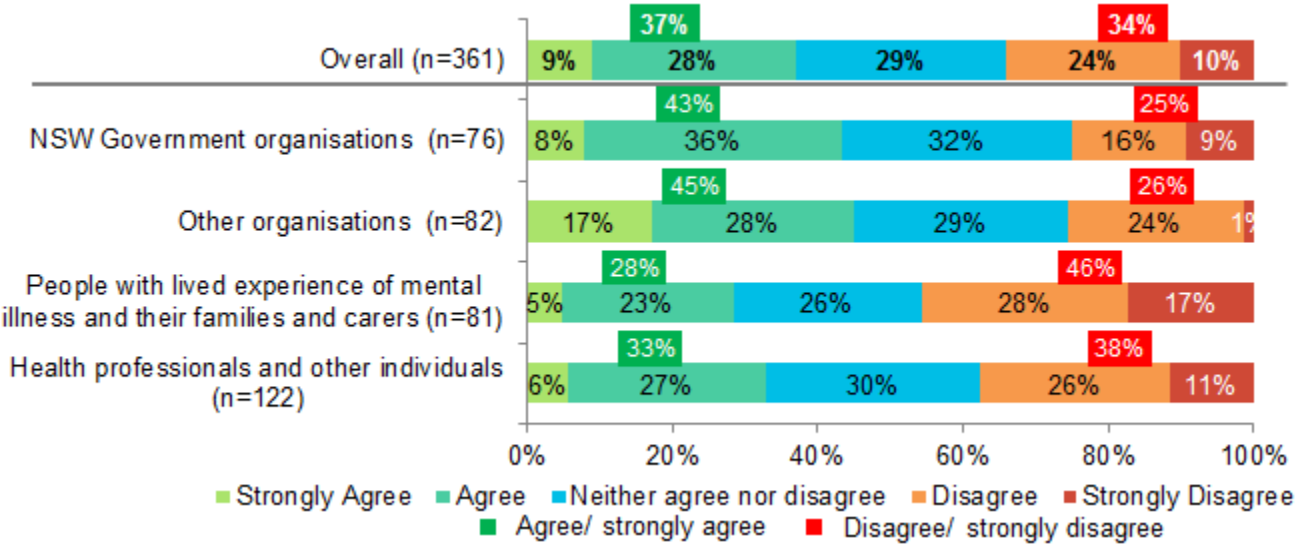


### 1.7.5.3 The whole community

Having explored the perceived success of the Commission in engaging with specific stakeholders, the consultation asked how successful their work had been in engaging with the whole community.

Just over a third (37%) of submissions felt that the Commission had been successful in this respect. Submissions from individuals within the community were less likely to agree with this statement than those representing NSW Government or other organisations.

Figure 27: Level of agreement that the Commission has effectively engaged and consulted with *the whole community*, overall and by high level organisation and individual groupings (n=361)



## 1.8 How the Commission has worked - Principles

Section 11 of the Act set out the principles governing the work of the Commission.

Respondents were most positive about the Commission having:

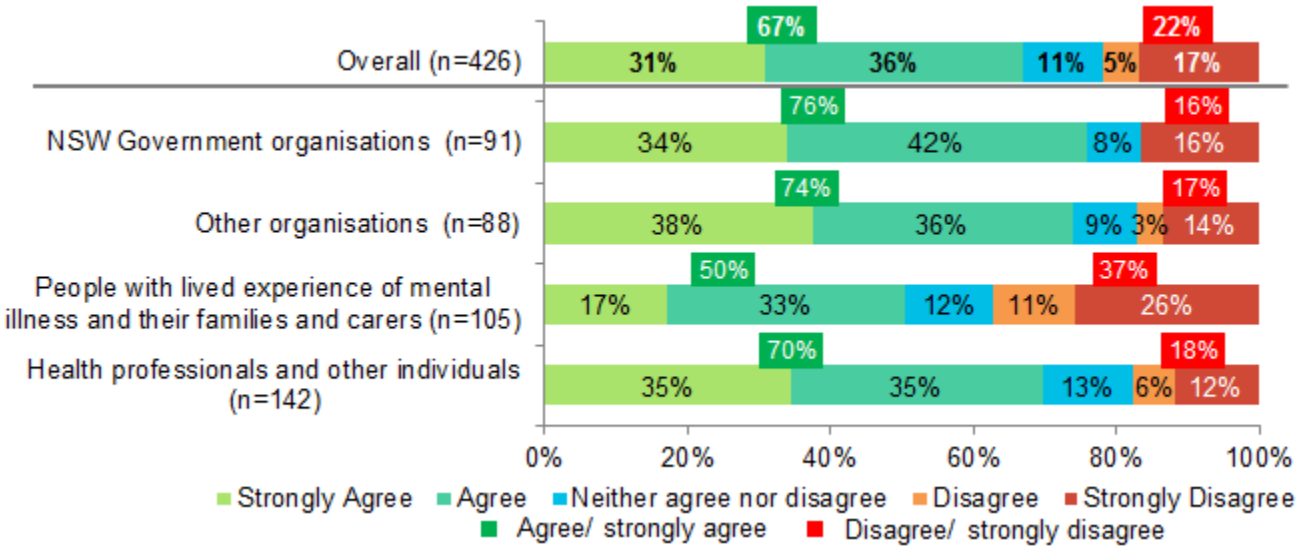
- worked to the principles that people with mental illness should have access to the best possible care, are treated with dignity and respect, and are supported to live fully in community life and lead meaningful lives (67%)
- enhanced communication and collaboration with consumers, carers and stakeholders (53%)
- operated from a *whole of government* and *whole of community* perspective (42%).

The lowest proportions of agreement were recorded for enhanced integration and coordination across the sector having existed, including in the areas of health, housing, employment, education and justice (34%), and for clarity of alignment having existed between the work of the Commission and other NSW Government agencies (38%).

### 1.8.1 The best possible care, dignity and respect, and meaningful lives

Two thirds (67%) of submissions agreed/ strongly agreed that the Commission works to the relevant quality of care principles for people with mental illness. Out of the four broad segments, three showed high levels of endorsement (70% or higher). The exception was the segment including people with lived experience of mental illness and their carers (50%).

Figure 28: Level of agreement that the Commission *works to the principles that people with mental illness should have access to the best possible care, are treated with dignity and respect, and are supported to live fully in community life and lead meaningful lives*, overall and by high level organisation and individual groupings (n=426)




### 1.8.2 Collaboration and integration

The final principle outlined under the Act, for the Commission to operate by, is that *an effective mental health system requires:*

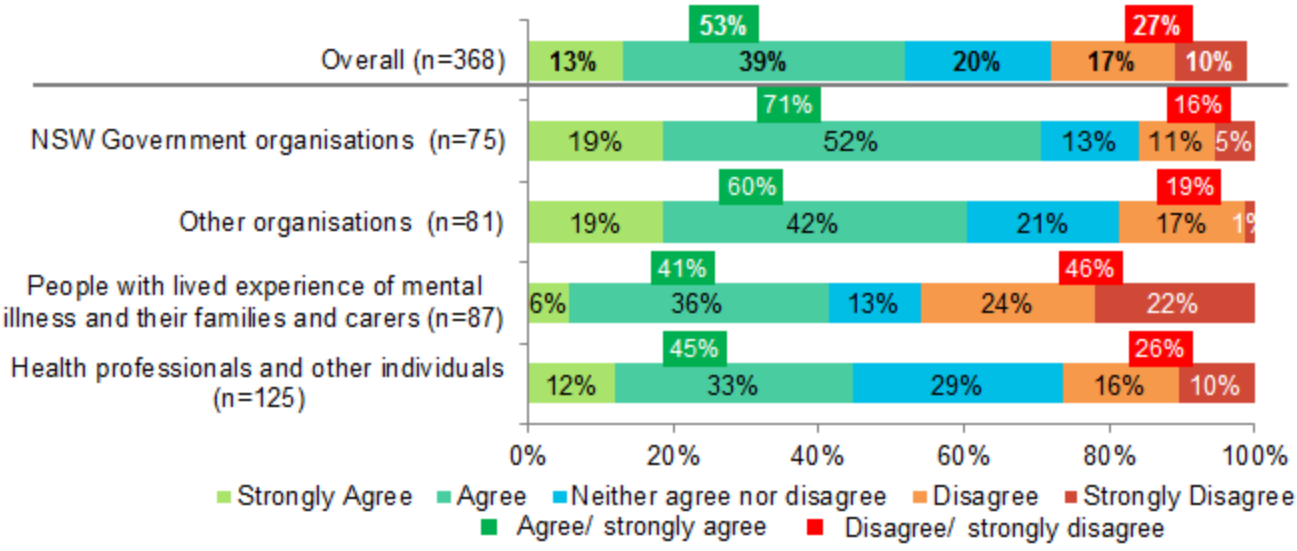
- *communication and collaboration between people who have a mental illness and their families and carers, providers of mental health services and the whole community*
- *a co-ordinated and integrated approach across all levels of government and the non-government sector, including in the areas of health, housing, employment, education and justice.*

### 1.8.2.1 Consumers, carers and stakeholders

Around one in two (53%) of submissions agreed/strongly agreed with the consultation question relating to whether the Commission has enhanced communication and collaboration with its stakeholders. Just over a quarter (27%) disagreed/ strongly disagreed, and a high proportion (20%) put themselves in the 'neither' category (perhaps indicating that respondents did not have the knowledge or awareness to voice an opinion).

NSW Government and other organisations, i.e. the stakeholders that the Commission is likely to have most direct contact with, were most positive about the Commission's efforts in this area (71% and 60% agree/ strongly agreed that communication had been enhanced by the Commission). People with lived experienced of mental illness and their families and carers, and health professionals, were less aware of communication having been enhanced (41% and 45% agreed/strongly agreed, respectively).

Figure 29: Level of agreement that the Commission has *enhanced communication and collaboration with consumers, carers and stakeholders,* overall and by high level organisation and individual groupings (n=368)



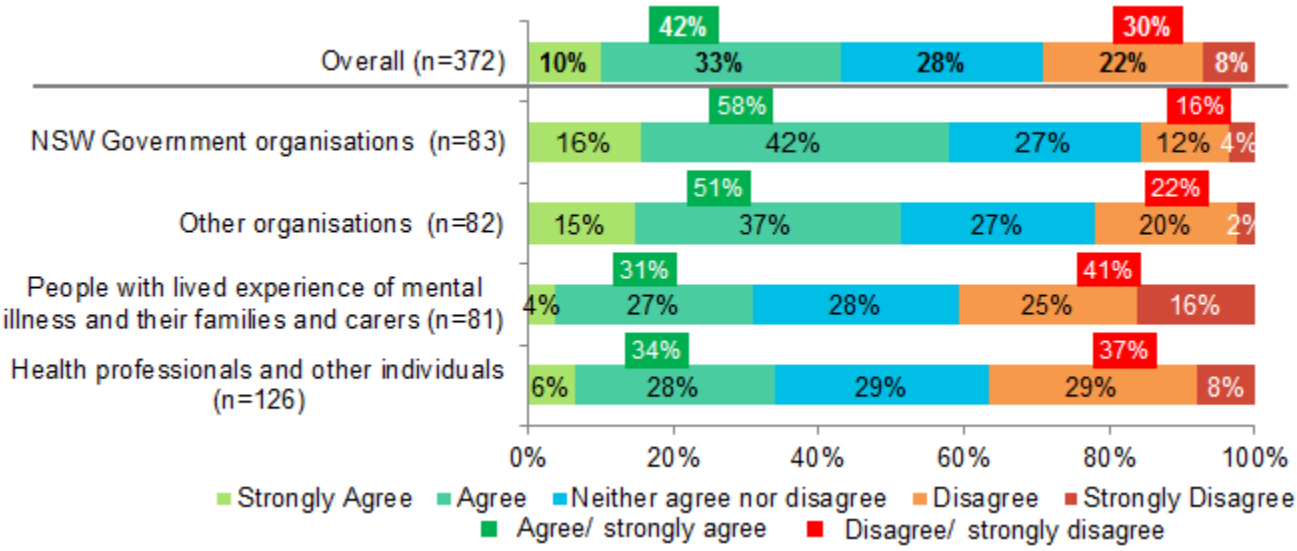
### 1.8.2.2 Holistic perspective

The consultation asked for views on whether the Commission had acted from a 'whole of government' and 'whole of community' perspective.

Two fifths (42%) of submissions agreed/ strongly agreed that the Commission had taken a holistic approach, and three in ten (30%) disagreed/ strongly disagreed. Nearly three in ten (28%) of submissions indicated that they neither agreed nor disagreed with this statement (perhaps indicating a lack of necessary understanding or awareness to voice an opinion).

Levels of agreement ranged from around a third of the individual segments, through to more than a half of NSW Government and other organisations.

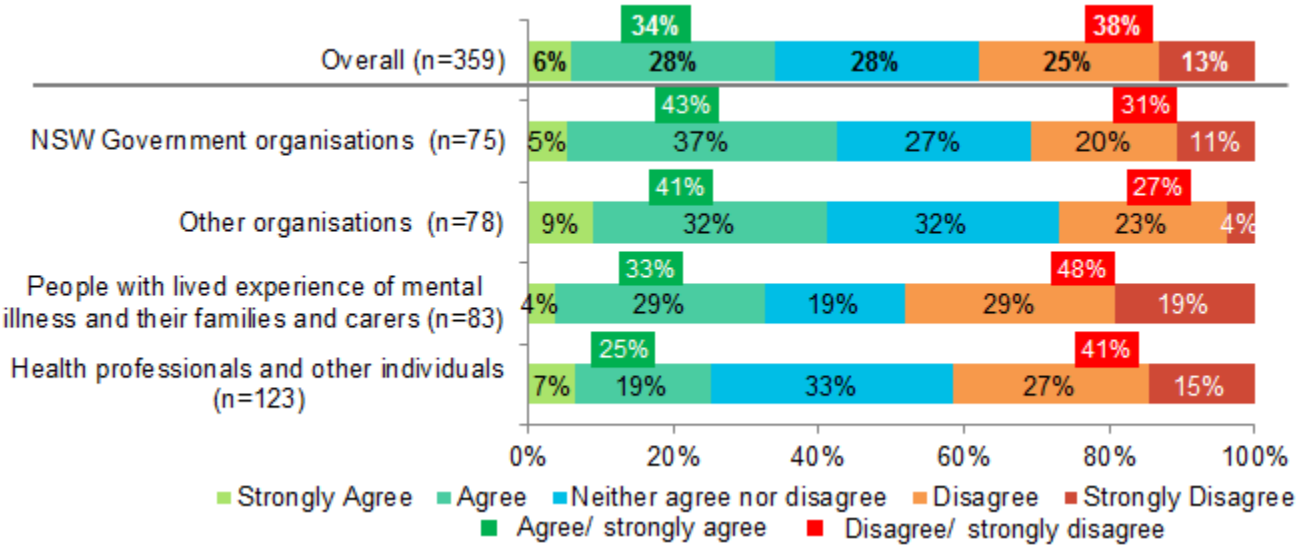
Figure 30: Level of agreement that the Commission has *operated from a 'whole of government' and 'whole of community' perspective*, overall and by high level organisation and individual groupings (n=372)



### 1.8.2.3 Coordination across the sector

In response to the consultation question regarding whether the Commission has enhanced integration and coordination across the sector, submissions were equally split between broad agreement (34%) and broad disagreement (38%), with more than a quarter (28%) remaining neutral. Submissions from NSW Government were the most positive in response to this statement (43%) while health professionals and other individuals were the least (25%).

Figure 31: Level of agreement that the Commission has *enhanced integration and coordination across the sector, including in the areas of health, housing, employment, education and justice,* overall and by high level organisation and individual groupings (n=359)



### 1.8.3 Alignment between the work of the Commission and others

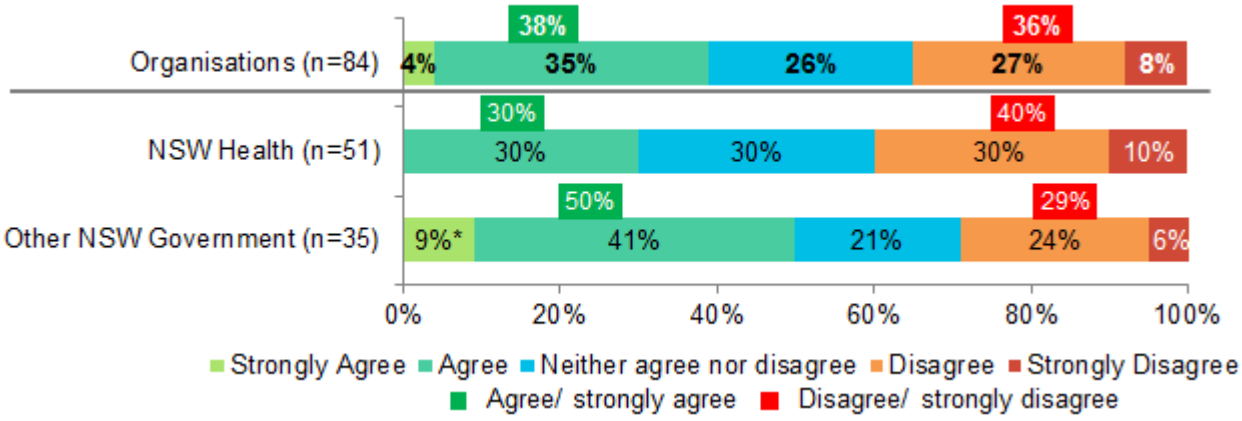
Under the Act, the fourth principle which governs the Commission's work is that *the promotion of good mental health and the effective provision of mental health services are the shared responsibility of the government and non-government sectors*.

#### 1.8.3.1 Alignment with NSW Government agencies

Those who indicated that their submission was from within NSW Health, or other NSW Government agencies, were asked whether they considered the work of the Commission to be aligned with that of other state government agencies. Results were polarised, with just over a third both agreeing/ strongly agreeing (38%) and disagreeing/ strongly disagreeing (36%). The remaining quarter (26%) neither agreed nor disagreed.

Less than a third of NSW Health respondents agreed/strongly agreed (30%), compared with half of 'other' NSW Government organisations (50%).

Figure 32: Organisations' level of agreement that *there is clarity of alignment between the work of the Commission and other NSW Government agencies*, overall and by organisation type (n=84)

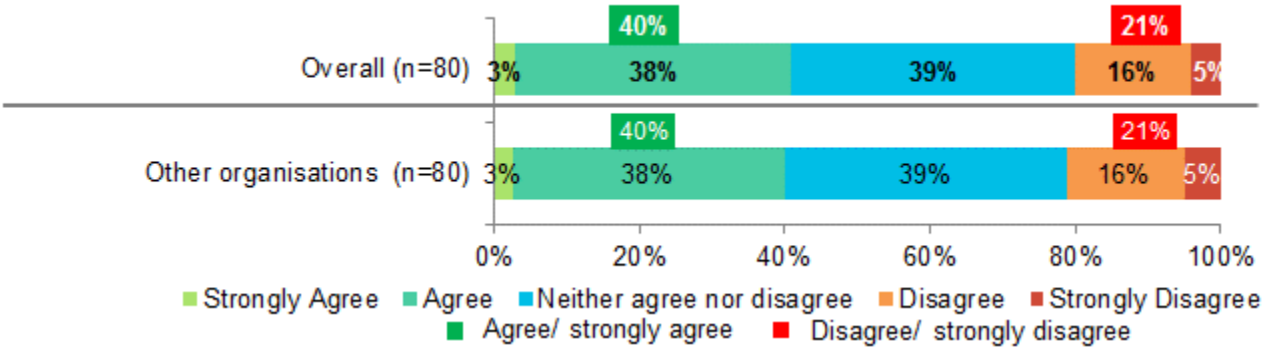


### 1.8.3.2 Alignment with the broader mental health system

Non-government organisations were asked to rate their level of agreement with a statement that the work of the broader mental health system and the work of the Commission were clearly aligned.

Submissions were more positive about the Commission's alignment with the broader health system, with two fifths (40%) of responses agreeing/ strongly agreeing and one fifth (21%) disagreeing/ strongly disagreeing. There was a relatively high proportion of neutral responses for this question (39%).

Figure 33: Level of agreement that *the work of the broader mental health system and the work of the Commission are clearly aligned,* overall and by high level organisation grouping (n=80)




## 1.8.4 Future principles

All respondents were asked whether they thought that the same principles that currently govern the work of the Commission should continue to underpin the Commission's work, or whether they thought any changes should be considered, and, if so, what changes?

Thirty-nine percent of overall submissions indicated that the same principles should continue to apply, without change (39%). This proportion was markedly higher among NSW Government submissions (56%) and other organisations (45%) than among individuals with lived experience and their carers (25%) and other individuals (35%).

> *"We would agree that these principles should continue to underpin the work of the MHC."* [Other NSW Government]
>
> *"Yes - but they should actually use them!"* [Mental health service provider or non-government organisation]
>
> *"Absolutely … there is still work to be done in educating the community and other parts of government and non-government agencies about such programs as 'Recovery' principals."* [Other NSW Government]

### 1.8.5 Suggestions for being more strategically focused

All respondents were also asked how they thought the work of the Commission might be more strategically focused, in the context of the broader Government and mental health system.

A third of respondents suggested that the Commission become more strategically focused by working more closely with all stakeholders, from consumers, carers and communities, to health care professionals and service providers (33%).

> *"Working more with stakeholders, carers and people with mental illness and advocating more around the challenges of the NDIS for clients."* [Other not-for-profit organisation]
>
> "*Listening to carers /consumers and doctors. Communicating on a regular basis with the government via our MPs, peak bodies, committees and forums. Insist on the changes and make sure the laws and regulations are applied vigorously."* Peak body / representative non-government organisation]
>
> *"Enhance its community engagement strategies, so it can reach the grassroots or hard to reach consumers, communities and groups."* [Other professional]
>
> *"Work with the lowest rank mental health staff, then work upwards to senior management."* [Health professional]
>
> *"The Commission needs to work from the ground up, and advocate for consumer wellbeing at all parts of the consumer journey within the health system."* [A person with lived experience of mental illness]

## 1.9 Future directions

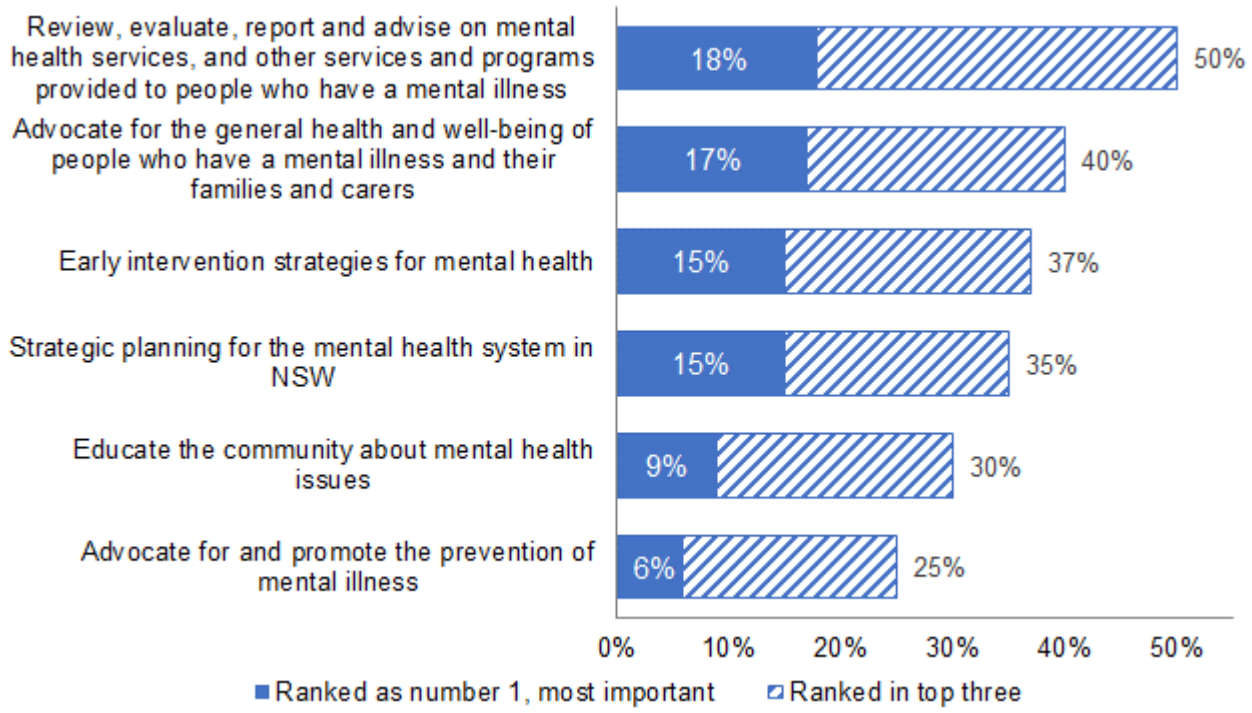
Section 20 of the Act, stipulates that the review will include an assessment of *whether the policy objectives of the Act remain valid and whether the terms of the Act remain appropriate for securing those objectives*. In reference to this, the online consultation sought feedback on what respondents considered most important for the Commission in the future.

The most important, existing priority for the Commission to continue to focus on, ranked in the top three by one in two submissions (and first by one fifth), was the role of reviewing, evaluating and advising on mental health services (50% in top three; 18% as most important).

This was followed closely by an advocacy role (40% ranked this in the top three; and 17% first), early intervention strategies for mental health (37% and 15% respectively) and strategic planning for the mental health system in NSW (35% and 15% respectively).

Three in ten submissions indicated (in their top three) that the Commission should focus on educating the community around mental health issues (30%); and a quarter highlighted the importance of promoting the prevention of mental illness (25%).

Figure 34: Future function areas – top six areas ranked as most important, and in top three for importance, by respondents, overall (n=398)




When asked to state, in their own words, what they thought the highest priority should be for the Commission now, or in the near future, the most important function was considered to be advocating for people with mental illness and ensuring adequate and quality support and care is provided to them (18%).

> *"Advocacy for those with mental health conditions, and keep the needs of those experiencing a loss of mental wellbeing at the forefront of reform."* [Mental health service provider or non-government organisation]
>
> *"Examine consumers' priorities against government priorities. Develop a strategic plan that aligns these more effectively."* [Other organisation]
>
> *"More support for those with mental health problems to reduce suicide."* [A person with lived experience of mental illness]
>
> *"Planning our NSW services for the next 5, 10 and 20 years, with a focus on quality of life and mental wellness."* [Health professional]

*"More funding for mental health care services, in order to address specific population needs."* [Health professional]

*"Accessibility to quality treatment / care."* [A person with lived experience of mental illness]

## 1.10 Additional information

More details on the results of the Mental Health Commission review's online consultation survey are available in the full report.

# Appendix A: Questionnaire

| |
|---|
| NSW Mental Health Commission Review – Online survey |
| AU3000426 |
| 30 October 2017 |
| NSW Health |

# Introduction

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

The Act required that a Review be undertaken after five years to consider whether the Commission has met the objectives of the Act, as well as its future roles and functions.

More information on the Review can be found here NSW Ministry of Health's website

The Ministry of Health now invites you to take part in the Review through this online consultation survey being conducted by independent research company, ORC International.

The Survey asks you to rate your level of agreement with statements and provides opportunities for further comment. Please limit each of your comments to no more than 300 words.

Not all questions may be relevant to your experience and if not, skip that question or answer don't know/prefer not to say.

The survey should take approximately 15 minutes to complete depending on the detail of your answers.

The survey is open until **5pm, Tuesday 7 November 2017**.

At any time during the survey, you can save your responses and return to them at a later time. Simply click the 'Save to return later' button located in the top right hand corner. You will be asked to provide an email address for a return link.

If you have any questions about this survey, please contact ORC International's support desk by clicking the 'Help' link within the survey.

If you have any questions about the review of the Mental Health Commission, please phone the Mental Health Branch, at the Ministry of Health, on 9461 7658, or email MHC_Review@doh.health.nsw.gov.au.

# Consent

C1. Your survey responses will be used by ORC International for research purposes only and no identifying details are needed. Results will be reported to the Ministry of Health in aggregate, and will be used to inform the Review of the Mental Health Commission.

ORC International will also make available to the Ministry the raw survey data, containing individual submissions in full and including any comments you make. This may be used by the Ministry to support additional analysis and reporting.

Do you consent to your complete response to this consultation survey, including any comments you may choose to provide, being provided to the Ministry of Health?

*(Note that if you change your mind, you are able to return to this question later, while completing the survey, and change your answer.)*

*Single response - please select one answer only*

| | |
|---|---|
| Yes, please make my full response data, including my unedited verbatim comments, available to the Ministry of Health | 1 |
| No, please only use my non-identifiable responses in aggregated reporting | 2 |

# Demographics

D1. We would first like to ask some questions about you and your organisation.

Are you taking part as an individual, or as a member of an organisation?

*Single response - please select one answer only*

| | |
|---|---|
| Organisation | 1 |
| Individual | 2 |

ANSWER IF D1 = 1 (Organisation)

D2. How would you describe your organisation?

*Please select one, main category only.*

| | |
|---|---|
| Peak body / representative non-government organisation | 1 |
| Mental health service provider or non-government organisation | 2 |
| Other not-for-profit organisation | 8 |
| NSW Health | 3 |
| Other NSW Government (Please specify) | 4 |
| Research/university sector | 6 |
| Other (Please specify) | 96 |

ANSWER IF D1 = 2 (Individual)

D3. How would you describe your individual background:

*Please select one, main category only.*

| | |
|---|---|
| A person with lived experience of mental illness | 1 |
| A family member or carer of a person with mental illness | 2 |
| Health professional | 3 |
| Other professional | 4 |
| Member of the public (none of the above) | 5 |

ANSWER IF D1 = 2 (Individual)

D4. Are you:

*Single response - please select one answer only*

| | |
|---|---|
| Male | 1 |
| Female | 2 |
| Other | 96 |
| Don't know/ Prefer not to answer | 99 |

ANSWER IF D1 = 2 (Individual)

D4A. Are you aged:

*Single response - please select one answer only*

| | |
|---|---|
| 24 or under | 1 |
| Over 24 years old | 2 |
| Don't know/ Prefer not to answer | 99 |

ANSWER IF D1 = 2 (Individual)

D5. Are you of Aboriginal or Torres Strait Islander origin?

*Single response - please select one answer only*

| | |
|---|---|
| Yes, Aboriginal | 1 |
| Yes, Torres Strait Islander | 2 |
| Yes, Aboriginal and Torres Strait Islander | 3 |
| No | 4 |
| Don't know/ Prefer not to answer | 99 |

ANSWER IF D1 = 2 (Individual)

D6. Do you speak a language other than English at home?

*Single response - please select one answer only*

| | |
|---|---|
| Yes | 1 |
| No | 2 |
| Don't know/ Prefer not to answer | 99 |

ANSWER IF D1 = 2 (Individual)

D6A. Were you born in Australia?

*Single response - please select one answer only*

| | |
|---|---|
| Yes | 1 |

| | |
|---|---|
| No | 2 |
| Don't know/ Prefer not to answer | 99 |

D7. What is your postcode?

_ _ _ _

☐ Prefer not to answer

# Functions under the Act

## 1.11 The strategic plan

Q1a. To what extent are you familiar with the work of the Mental Health Commission?

*Please rate the extent of your familiarity on a scale of 1 to 5, where 1 is 'Not at all' and 5 is 'Very'.*

| | | | | | | |
|---|---|---|---|---|---|---|
| Not at all<br>1 | 2 | 3 | 4 | Very<br>5 | | Don't know/ Prefer not to answer<br>99 |

Q1. The Mental Health Commission was required to prepare a draft **strategic plan** for the mental health system in New South Wales, and report on its implementation.

The plan *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024* was released in 2014.

The implementation report, *One Year On: Progress Report on the Implementation of Living Well*, was released in 2015.

To what extent do you agree or disagree with the following statements?

**The Mental Health Commission has...**

| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | | Don't know/ Prefer not to answer |
|---|---|---|---|---|---|---|---|---|
| A | Produced an effective strategic plan | 1 | 2 | 3 | 4 | 5 | | 99 |
| B | Sufficiently monitored and reported on the implementation of the Plan | 1 | 2 | 3 | 4 | 5 | | 99 |

ANSWER IF (Q1A OR Q1B) = (1 OR 2 OR 3 OR 4 OR 5) - Gave a rating

Q2. What do you think the impact of the strategic plan has been on the mental health system, and the mental health and wellbeing of the people of NSW?

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

## 1.12 Mental health services and programs

Q3. The Act also required the Mental Health Commission to review, evaluate, report and advise on mental health services and programs provided to people who have a mental illness, and other issues affecting people who have a mental illness.

Do you agree that the Mental Health Commission has effectively...

| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | | Don't know/ Prefer not to answer |
|---|---|---|---|---|---|---|---|---|
| A | Reviewed and evaluated mental health and other services, programs and issues | 1 | 2 | 3 | 4 | 5 | | 99 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| B | Reported and advised on mental health and other services, programs and issues | 1 | 2 | 3 | 4 | 5 | | 99 |

ANSWER IF (Q3A OR Q3B) = (4 OR 5) – Gave a rating of Agree or Strongly agree .

Q4. What do you think have been the most significant achievements of the Mental Health Commission in this regard?

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

IF ((Q3A or Q3B) = (1 OR 2 OR 3)) - Gave a rating of Disagree or Strongly disagree or Neither agree nor disagree.

Q4A. How could the Mental Health Commission more effectively focus this work?

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

## 1.13 Knowledge sharing

Q5. Do you agree or disagree that the Mental Health Commission has promoted and facilitated knowledge sharing about mental health issues in an effective way?

*Single response - please select one answer only*

| | |
|---|---|
| Strongly disagree | 1 |
| Disagree | 2 |
| Neither agree nor disagree | 3 |
| Agree | 4 |
| Strongly agree | 5 |
| Don't know/ Prefer not to answer | 99 |

IF Q5 = 1 OR 2 OR 3 OR 99 - Gave a rating of Disagree or Strongly disagree or Neither agree nor disagree OR Don't know/ Prefer not to answer)

Q6. What do you think the Mental Health Commission could do to further promote and facilitate the sharing of knowledge about mental health issues?

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

IF Q5 = 4 OR 5 – Gave a rating of Agree or Strongly agree .

Q7. Please provide one example, from your experience at any time during the *last five years* that best shows how the Mental Health Commission has promoted and facilitated sharing of knowledge about mental health issues.

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

## 1.14 Research and education

Q8. Do you agree or disagree that the Mental Health Commission has effectively undertaken...

| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | | Don't know/ Prefer not to answer |
|---|---|---|---|---|---|---|---|---|
| A | Research | 1 | 2 | 3 | 4 | 5 | | 99 |
| B | Innovation | 1 | 2 | 3 | 4 | 5 | | 99 |
| C | Policy development | 1 | 2 | 3 | 4 | 5 | | 99 |
| D | Initiatives to educate the community about mental health issues (including to reduce the stigma and discrimination) | 1 | 2 | 3 | 4 | 5 | | 99 |

ANSWER IF (Q8A OR Q8B OR Q8C OR Q8D) = (1 OR 2 OR 3 OR 4 OR 5) – Gave a rating

Q9. Please give an example of research, innovation, policy development, or an education initiative, that the Mental Health Commission has undertaken.

Briefly describe the impact that it had on the mental health sector or the mental health and wellbeing of the people of NSW.

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

## 1.15 Advocacy

Q10. Do you agree or disagree that the Mental Health Commission has effectively fulfilled its functions to advocate for and promote...

| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | | Don't know/ Prefer not to answer |
|---|---|---|---|---|---|---|---|---|
| A | The prevention of mental illness and early intervention strategies for mental health | 1 | 2 | 3 | 4 | 5 | | 99 |
| B | The general health and wellbeing of people who have a mental illness and their families | 1 | 2 | 3 | 4 | 5 | | 99 |

ANSWER IF (Q10A OR Q10B) = (1 OR 2 OR 3 OR 4 OR 5) – Gave a rating

Q11. What impact have the Mental Health Commission's advocacy and promotion activities had on the mental health sector or the mental health and wellbeing of the people of NSW?

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

# The Ministerial Charter letter of 2016

L1. The Ministerial Charter letter of 2016 identified a number of priorities for the Mental Health Commission for 2016-17.

Taking two of these, do you agree or disagree that the Mental Health Commission has effectively done the following...

| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | | Don't know/ Prefer not to answer |
|---|---|---|---|---|---|---|---|---|
| A | Ensured that the NDIS take appropriate account of the needs of people with psychosocial disability as a consequence of mental illness | 1 | 2 | 3 | 4 | 5 | | 99 |
| B | Developed innovative responses to the particular mental health and wellbeing needs of young people | 1 | 2 | 3 | 4 | 5 | | 99 |

# Operations

O1. Thinking about all the work done by the Mental Health Commission, since 2012, to what extent do you agree or disagree that it has...

| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | | Don't know/ Prefer not to answer |
|---|---|---|---|---|---|---|---|---|
| A | Focused on system wide mental health issues | 1 | 2 | 3 | 4 | 5 | | 99 |

O2. And, to what extent do you agree or disagree that its work has taken into account ...

| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | | Don't know/ Prefer not to answer |
|---|---|---|---|---|---|---|---|---|
| A | Co-morbidity (e.g. drug and alcohol, disability) | 1 | 2 | 3 | 4 | 5 | | 99 |
| B | The interaction between people who have a mental illness and the criminal justice system | 1 | 2 | 3 | 4 | 5 | | 99 |
| C | The needs of Aboriginal people and communities | 1 | 2 | 3 | 4 | 5 | | 99 |
| D | The needs of culturally and linguistically diverse communities | 1 | 2 | 3 | 4 | 5 | | 99 |
| E | The needs of regional and remote communities | 1 | 2 | 3 | 4 | 5 | | 99 |

O3. Do you agree or disagree that the Commission has effectively engaged and consulted with …

| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | | Don't know/ Prefer not to answer |
|---|---|---|---|---|---|---|---|---|
| A | People who have a mental illness | 1 | 2 | 3 | 4 | 5 | | 99 |
| B | Families and carers of people with a lived experience of mental illness | 1 | 2 | 3 | 4 | 5 | | 99 |
| C | NSW Government | 1 | 2 | 3 | 4 | 5 | | 99 |
| D | The non-Government sector | 1 | 2 | 3 | 4 | 5 | | 99 |
| E | The whole community | 1 | 2 | 3 | 4 | 5 | | 99 |

ANSWER IF O1 = (1 OR 2 OR 3 OR 4 OR 5) – Gave a rating

O4. Please give an example of how the Commission has successfully focused on system-wide mental health issues, and describe the impact of this.

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

# How the Commission has worked - Principles

P1. Please indicate your level of agreement with the following statement.

The Mental Health Commission works to the principles that people with mental illness should have access to the best possible care, are treated with dignity and respect, and are supported to live fully in community life and lead meaningful lives.

*Single response - please select one answer only*

| | |
|---|---|
| Strongly disagree | 1 |
| Disagree | 2 |
| Neither agree nor disagree | 3 |
| Agree | 4 |
| Strongly agree | 5 |
| Don't know/ Prefer not to answer | 99 |

P2. Do you agree or disagree that the Mental Health Commission has...

| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | | Don't know/ Prefer not to answer |
|---|---|---|---|---|---|---|---|---|
| A | Enhanced communication and collaboration with consumers, carers and stakeholders | 1 | 2 | 3 | 4 | 5 | | 99 |
| B | Operated from a *whole of government and whole of community* perspective | 1 | 2 | 3 | 4 | 5 | | 99 |
| C | Enhanced integration and coordination across the sector, including in the areas of health, housing, | 1 | 2 | 3 | 4 | 5 | | 99 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | employment, education and justice | | | | | | | |

P3. Do you think these principles (listed in the last two questions) should continue to underpin the Mental Health Commission's work, or are there any changes you think should be considered? If so, what?

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

ANSWER IF D2 = 3 OR 4 (NSW Government, NSW Health)

P4_Q1. To what extent do you agree or disagree that there is clarity of alignment between the work of the Commission and other NSW Government agencies?

*Single response - please select one answer only*

| | |
|---|---|
| Strongly disagree | 1 |
| Disagree | 2 |
| Neither agree nor disagree | 3 |
| Agree | 4 |
| Strongly agree | 5 |

| | |
|---|---|
| Don't know/ Prefer not to answer | 99 |

ANSWER IF D2 = 1 OR 2 OR 6 OR 8 OR 96 (Other organisations)

P5_Q1. To what extent do you agree or disagree that the work of the broader mental health system and the work of the Commission are clearly aligned?

*Single response - please select one answer only*

| | |
|---|---|
| Strongly disagree | 1 |
| Disagree | 2 |
| Neither agree nor disagree | 3 |
| Agree | 4 |
| Strongly agree | 5 |
| Don't know/ Prefer not to answer | 99 |

ASK ALL

P6_Q1 How might the work of the Commission be more strategically focused, in the context of the broader Government and mental health system?

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

# Future directions

F1. Considering the functions of the Mental Health Commission listed below, and your understanding of the broader Government, advocacy, research and service delivery context, what are the **three most important things** that the Commission can focus on in the future?

*Please circle one number only, in each column.*

| | Most important | 2nd most important | 3rd most important |
|---|---|---|---|
| Strategic planning for the mental health system in NSW | 1 | 1 | 1 |
| Monitoring and reporting against a strategic plan | 2 | 2 | 2 |
| Review, evaluate, report and advise on mental health, and other services and programs | 3 | 3 | 3 |
| Promote and facilitate the sharing of knowledge across the mental health sector | 4 | 4 | 4 |
| Undertake and commission research | 5 | 5 | 5 |
| Undertake, commission and support innovation | 6 | 6 | 6 |
| Undertake policy development | 7 | 7 | 7 |
| Advocate for and promote the prevention of mental illness | 8 | 8 | 8 |
| Early intervention strategies for mental health | 9 | 9 | 9 |
| Educate the community about mental health issues | 10 | 10 | 10 |
| Advocate for the general health and well-being of people who have a mental illness and their families and carers | 11 | 11 | 11 |
| Other function - please specify | 12 | 12 | 12 |

☐ Don't know/ Prefer not to answer

F2. What do you think should be the highest priority for the Commission now, or in the near future?

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

# Other comments

E1. Are there any other comments you would like to make about the role, functions or work of the Mental Health Commission?

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

# Thank and close

We appreciate you taking the time to respond to this consultation survey.

This research is being conducted in keeping with the Australian Privacy Principles and the industry Privacy Code.

ORC International's privacy policy is available on our website (www.orcinternational.com).

Thank you.

# MENTAL HEALTH COMMISSION REVIEW – ONLINE CONSULTATION SURVEY

## Full report

Prepared For:

Mental Health Branch, NSW Ministry of Health

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12 December, 2017

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# Contents

# 1 Executive Summary

Appended separately.

# 2 Introduction

The Mental Health Commission of New South Wales (the Commission) is an independent statutory agency which was established in July 2012 under the *Mental Health Commission Act* (the Act), to monitor, review and improve the mental health system, as well as the mental health and wellbeing of the people of New South Wales.

The Act covers the establishment and operation of the Commission. It outlines the principles governing the Commission's work and details the Commission's functions, including the preparation of a strategic plan, and monitoring and reporting on the implementation of that strategic plan.

After its establishment, the Commission drafted a strategic plan, *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024,* which was adopted by the New South Wales Government in December 2014.

A couple of years later, the *Ministerial Charter letter of 2016* identified a number of specific priorities for the Mental Health Commission, for 2016-17.

The Act requires that a review be undertaken after five years to consider whether the Commission has met the objectives of the Act, as well as to appraise its future roles and functions. This is stipulated in Part 4 of the Act, which states that the Minister is required to undertake reviews of:

- the work of the Commission, taking into account the functions of the Commission and the principles governing the work of the Commission
- the Act, to determine whether the policy objectives of the Act remain valid and whether the terms of the Act remain appropriate for securing those objectives.

The review process commenced in July 2017, with the Minister releasing details of its Terms of Reference, and the appointment of Dr David Chaplow to lead the review.

The review will employ a range of public and stakeholder engagement strategies, including interviews, forums, an invitation for written submissions, and an online consultation survey.

In August, the Ministry of Health sought submissions from consultancies to conduct the online survey, and engaged ORC International to design, administer, manage and report on this survey.

This is ORC International's report on the results of the online consultation survey.

## 2.1 Objectives

The objectives of the online survey are to:

- provide a structured, publicly accessible feedback mechanism, to complement other consultation activities and enable broad participation in the review from people across the mental health, Government and broader health sector, including peak groups, key organisations, and consumers and other individuals in the community
- collect and report on the views of the above stakeholders, to contribute to the review of:
    - the extent to which the work of the Commission has met the objectives, functions and principles of the Act, in the context of the ongoing implementation of *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024*, which sets the overarching direction for mental health in New South Wales
    - the future role, functions, principles and priorities for the Commission.

# 3 Methodology

The project was carried out in compliance with ISO 20252 and membership requirements for AMSRO and AMSRS. It employed an open, public, online consultation survey instrument.

## 3.1 Online consultation process

The online consultation survey was designed to receive feedback from stakeholders in a manner that was structured to enable reasonably efficient analyses, whilst providing a medium for a large number of stakeholders to provide input to the review process.

The consultation survey was launched on 5 October and closed on 7 November, 2017.[1] It was hosted on ORC International's survey platform and was an open, public consultation, to which anyone could submit a response (in contrast to traditional market research online surveys to which participants are individually invited, with personalised, unique links). The consultation survey was accessed via a hyperlink on the Ministry of Health's website, or via the same hyperlink circulated by email. The Ministry of Health, the Mental Health Commission, the Mental Health Coordinating Council, Being, Mental Health Carers and other organisations publicised the online consultation and general invitation for responses, which included email invitations to participate being distributed by the Commission to contacts on its own stakeholder database.

ORC International also sent email invitations and reminders to participate in the survey, on behalf of the Ministry of Health, to a list of approximately 200 stakeholders provided by the Ministry. These blast outs were conducted on:

- 5 October
- 17 October
- 24 October
- 30 October.

It is important to note that, despite some being directly invited to participate, consultation respondents were self-selecting, with no sampling scheme applied and, therefore, the sample cannot be described as representative of the New South Wales population, or even

[1] Initially, the closing date was set for 4 December; however, it was extended during the open period to 7 December at the Ministry of Health's request. An IP checker had been requested by the Ministry to prevent multiple submissions from being entered from one computer, and this had prevented some organisations from completing multiple responses from within the same organisational network. The IP checker was removed and the live period extended to allow time for any organisations which had been effected to submit their responses.

representative of the Commission's stakeholder population; rather, it represents the views of those stakeholders who chose to submit a response to the consultation.

The questionnaire was designed by ORC International, together with the Ministry, and structured around the Act. It contained a mixture of closed questions, to provide quantitative data, and open-ended questions, to provide opportunities for respondents to phrase their own, albeit word constrained,[2] responses. Most of the closed questions were 5-point agreement scales, there was one 5-point extent scale, and one question which asked respondents to rank their three most important items (future functions) from a selection. The questionnaire can be viewed in Appendix B.

Respondents were able to either skip, or answer "Don't know/ prefer not to answer", to any question/s they chose to, with the exception of:

- their consent, or non-consent, to having their data provided to the Ministry of Health (the first question asked, question C1)
- whether they were answering as an individual or as a member of an organisation (question D1)
- either their organisation type, or individual background (question D2 or D3, depending on their response at D1).

Items in battery questions, laid out in a grid structure, and the potential future functions which respondents were asked to rank for importance were displayed in randomised order to minimise response bias.

For the analysis of free-text comments, coding frames were developed for each of the open-ended questions, based on an exploration of the themes and topics that emerged for each question. These coding frames were modified during the coding process, as new themes or topics emerged. Coding textual responses according to the coding frames enabled the large volume of 'qualitative' data to be analysed quantitatively, and the most prevalent topics to be concentrated on in reporting.

## 3.2 Respondent agreement to data being provided to the Ministry of Health

The Ministry of Health wished to be provided with the data from the online consultation survey, for possible additional analysis and reporting. While no identifying details were required from respondents, they were given a number of opportunities to enter free text

[2] Responses to open-ended questions had a 2,250 character limit imposed, and respondents were asked to limit their comments to no more than 300 words.

feedback, so all respondents were asked whether they consented to their "complete response to this consultation survey, including any comments [they] may choose to provide, being provided to the Ministry of Health."

Five hundred and fifty-four respondents (74%) consented to having their individual data records being made available to the Ministry.

ORC International provided the Ministry with the unedited records from all explicitly consenting respondents (n=554), in an Excel workbook.

Responses from respondents who did not consent to their individual data being forwarded to the Ministry were only included in aggregate reporting and, if their verbatim comments were used as examples in this report, potentially identifying information was omitted.

Table 1 lists the number of respondents who consented, and did not consent, to their full data being made available to the Ministry.

Table 1: Respondents consent to having their data provided to the Ministry of Health (n=753)

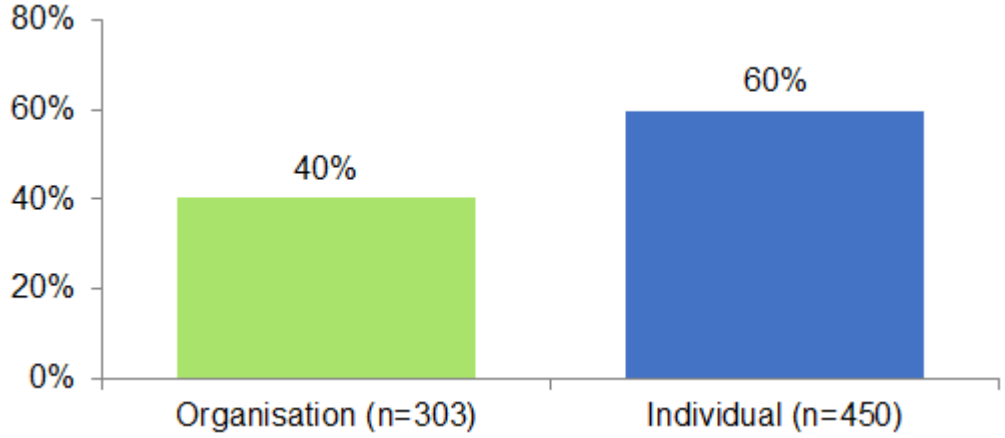
| | No. | Percentage |
|---|---|---|
| Yes, please make my full response data, including my unedited verbatim comments, available to the Ministry of Health | 554 | 74% |
| No, please only use my non-identifiable responses in aggregated reporting | 199 | 26% |
| Total | | 100% |

## 3.3 Profile of respondents

A total of 753 responses were submitted to the online consultation. This section describes the respondents according to their responses to the demographic questions.

The final sample contained 303 responses from representatives of organisations (40%), and 450 from individual respondents (60%), as shown in Figure 1.

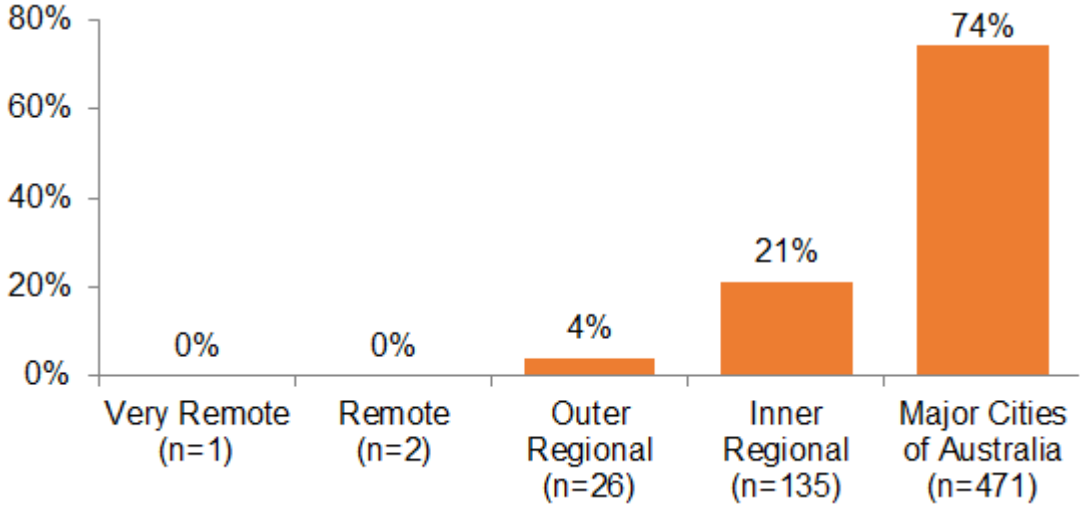
Figure 1: Percentage of organisations and individual respondents (n=753)




Respondents' remoteness categories were derived from their postcodes, where provided and valid,[3] using the Australian Bureau of Statistics classifications of remoteness contained in Catalogue 1270.0.55.006.[4] Six hundred and thirty-five (635) respondents provided valid postcodes (84%).

Only one respondent provided a postcode which indicated that they were from a very remote area, and two respondents provided postcodes which indicated that they were located in remote areas. Unsurprisingly given New South Wales' population distribution, the majority of respondents lived in major cities (74%), as shown in Figure 2.

Figure 2: Percentage of respondents who provided valid postcodes, by remoteness category (n=635)

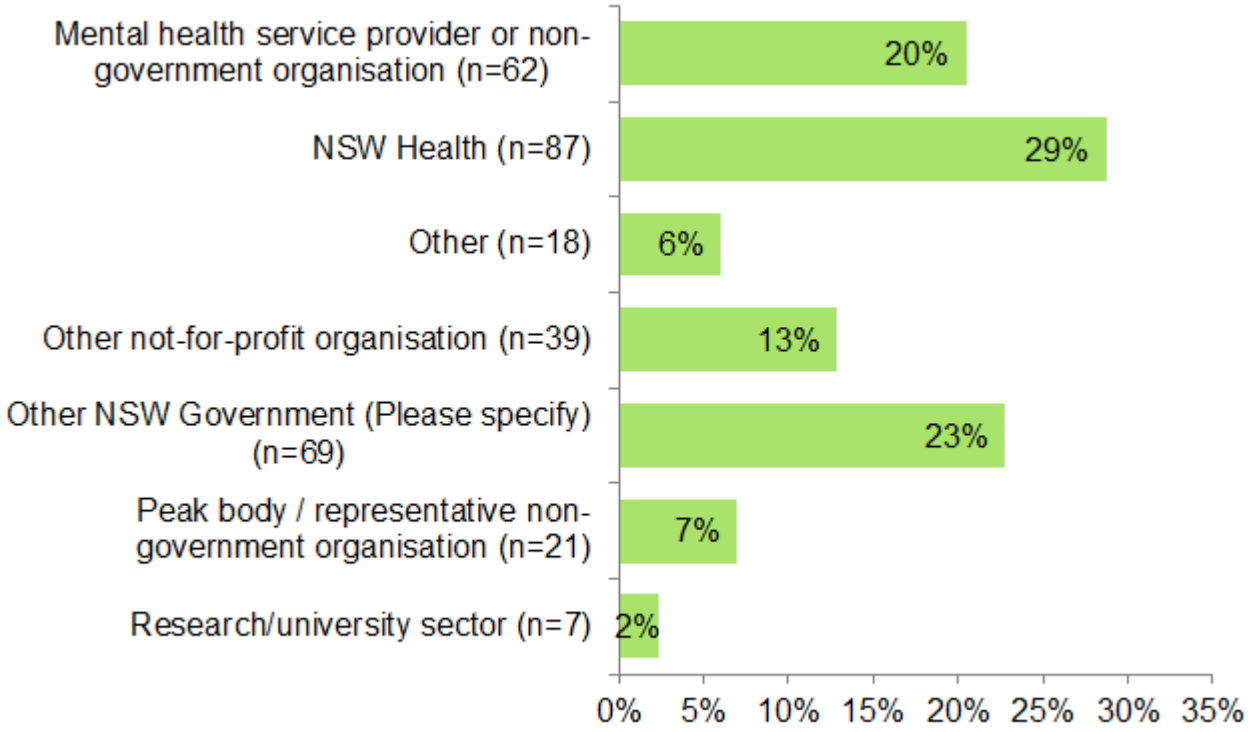



[3] Valid postcodes included New South Wales numbers recognised by Australia Post, excluding post office boxes (which do not indicate the location of a person's residence or place of business).
[4] ABS Cat. 1270.0.55.006, released 31 January 2013, based on Postcode 2012 to Remoteness Area 2011 data. In any instances where the postcode to remoteness area correspondence table contained more than one type of remoteness area within a postcode, for this analysis, the remoteness area to which the ABS had assigned the highest ratio for that postcode was used.

### 3.3.1 Organisations

All responding organisations were required to identify their type of organisation from a predefined category list. The 303 responding organisations comprised the organisation types shown in Figure 3. Respondents from New South Wales Health, other New South Wales Government, and from mental health service providers or other non-government organisations formed the highest proportions (29%, 23% and 20% respectively).

Figure 3: Percentage of organisation types (n=303)




New South Wales government organisations, other than NSW Health, were asked to specify what area of government they were from. The information was not mandatory, so not always provided by respondents. The areas specified by other government organisations, by those that did so (n=64), are listed in Table 2.

Table 2: Specified types of responding New South Wales government organisations, not NSW Health (n=64)

| Specified area of NSW government | No. |
|---|---|
| Aboriginal Affairs | 1 |
| CEC | 1 |
| Community controlled Aboriginal Health organisation | 1 |
| Council | 1 |
| Department of Education | 4 |
| Department of Premier and Cabinet | 2 |
| Education | 14 |
| FACS | 9 |
| FACS - Disability Inclusion | 1 |
| Family & Community Services (boarding house team) | 1 |
| Family and Community Services | 2 |
| Insurance & Care NSW | 1 |
| Justice | 1 |
| Legal Aid | 1 |
| Local Government | 9 |
| NSW Department of Education | 2 |
| NSW SES | 1 |
| Office of the NSW Small Business Commissioner | 1 |
| Official Visitor (MH) program | 1 |
| Official Visitors Program | 1 |
| Regulatory body | 1 |
| SafeWork NSW | 1 |
| Schools | 2 |
| Sydney water | 1 |
| Tribunal | 1 |
| **Total** | **64** |

Organisations which described themselves as "Other" (see the predefined categories for organisation type in Figure 3), were also asked to provide further details. The details specified by the 17 of the 18 "other" organisations that provided this information are listed in Table 3.

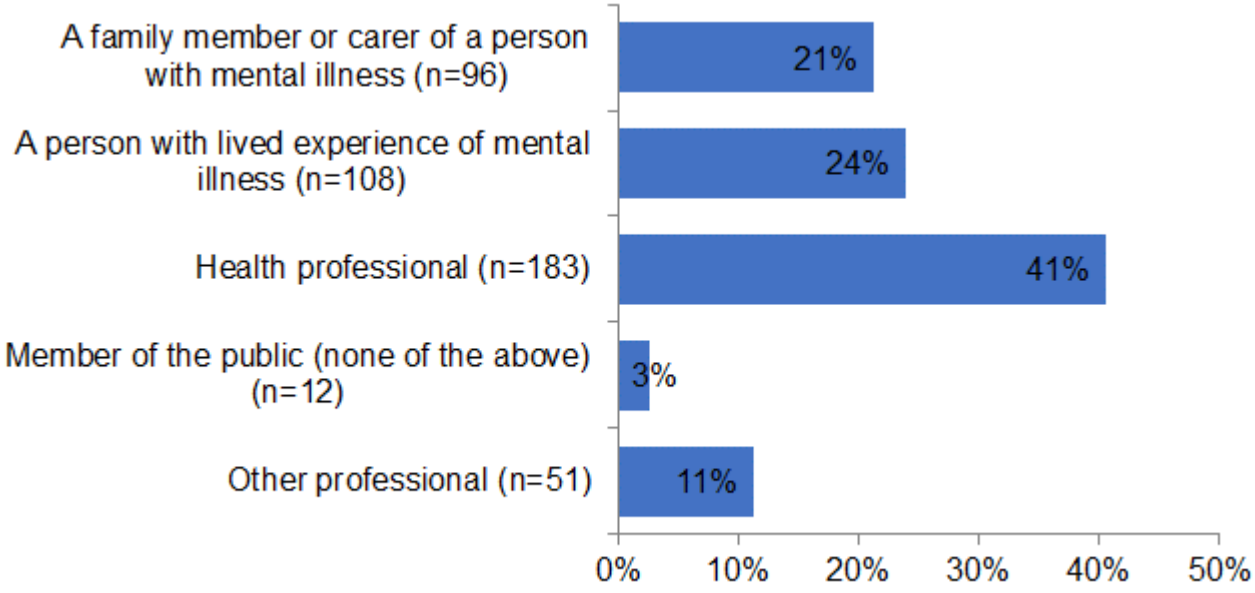
Table 3: Specified details of responding "other" organisations (n=17)

| Specified "other" organisation | No. |
|---|---|
| Aboriginal Medical Centre | 1 |
| Australian Government | 1 |
| communication agency | 1 |
| Community Association | 1 |
| disability employment | 1 |
| Independent School | 1 |
| internal audit service provider | 1 |
| Local Government | 1 |
| local health district health promotion | 1 |
| Loss & grief | 1 |
| NSW SES | 1 |
| Peer support - consumer & carer auspiced by One Door Mental Health | 1 |
| PHN | 1 |
| Private Clinic | 1 |
| Research, education and clinical services | 1 |
| Telco | 1 |
| Union/professional | 1 |
| **Total** | **17** |

### 3.3.2 Individuals

Individuals were asked to select one, main individual background description from a predefined list. As shown in Figure 4, health professionals represented 41% of the individuals, with people with lived experience of mental illness, and their family members and carers forming 24% and 21% respectively.

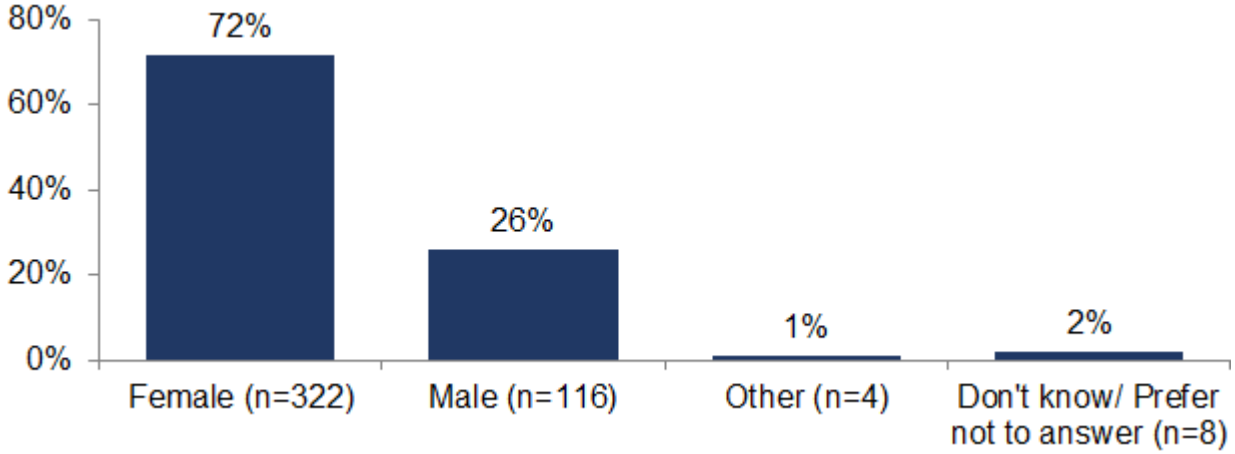
Figure 4: Percentage of individual respondents, by individual background (n=450)




Some additional demographic information was asked of respondents who answered the survey as individuals, and was provided on a voluntary basis. As these demographic questions may have been considered sensitive by some respondents, the percentages of individual respondents who opted to skip the question or who marked the "Don't know/ Prefer not to answer" tick box are included in the following figures.

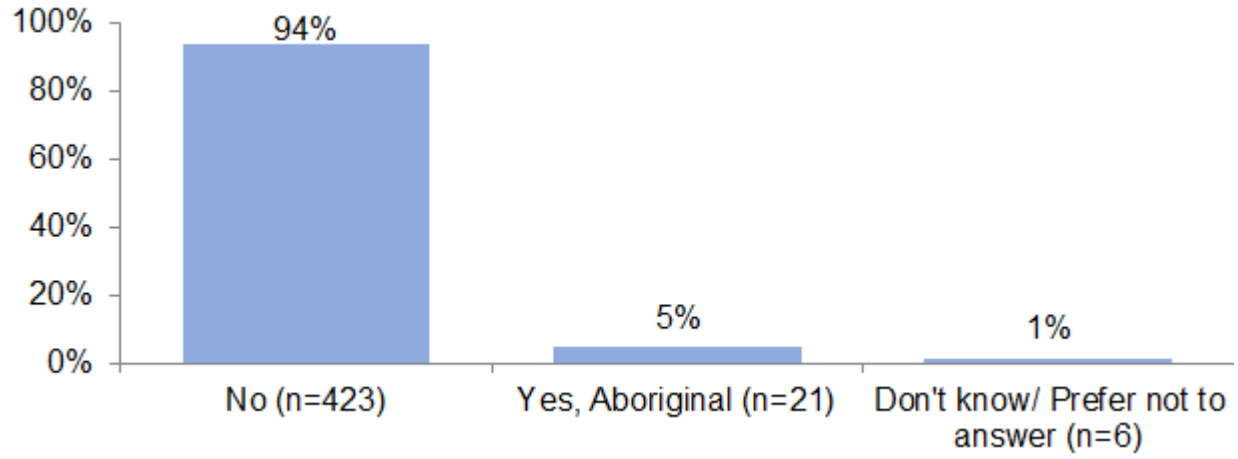
Approximately three-quarters of the individual respondents were women (72%), and one quarter were men (26%). There were four individuals who identified themselves as "other" gender.

Figure 5: Percentage of individual respondents, by gender (n=450)



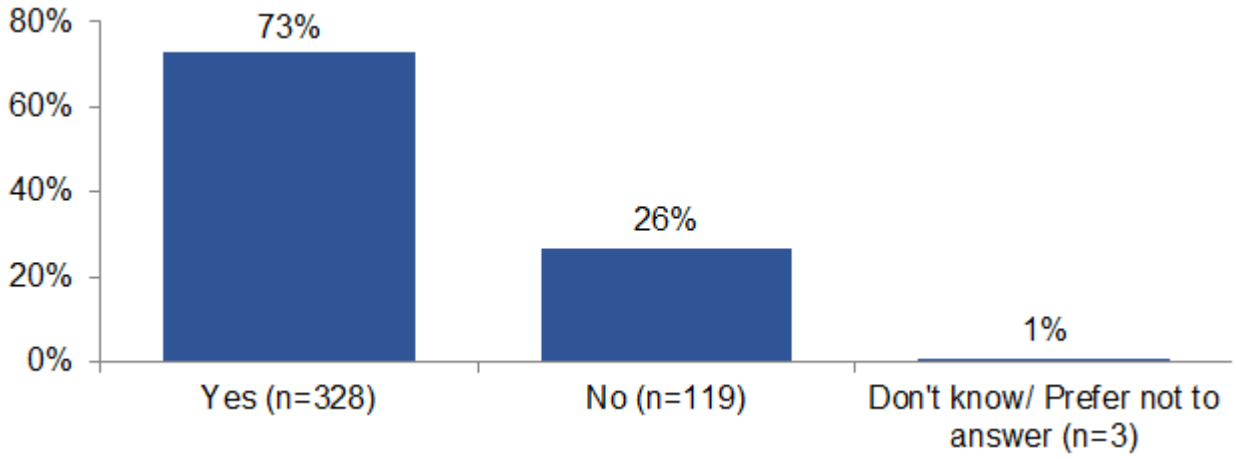
Five percent indicated that they were Aboriginal, when asked if they were of Aboriginal or Torres Strait Islander origin, as shown in Figure 6. No respondents identified themselves as either Torres Strait Islander, or both Aboriginal and Torres Strait Islander.

Figure 6: Percentage of individual respondents, by whether Aboriginal or Torres Strait Islander origin (n=450)



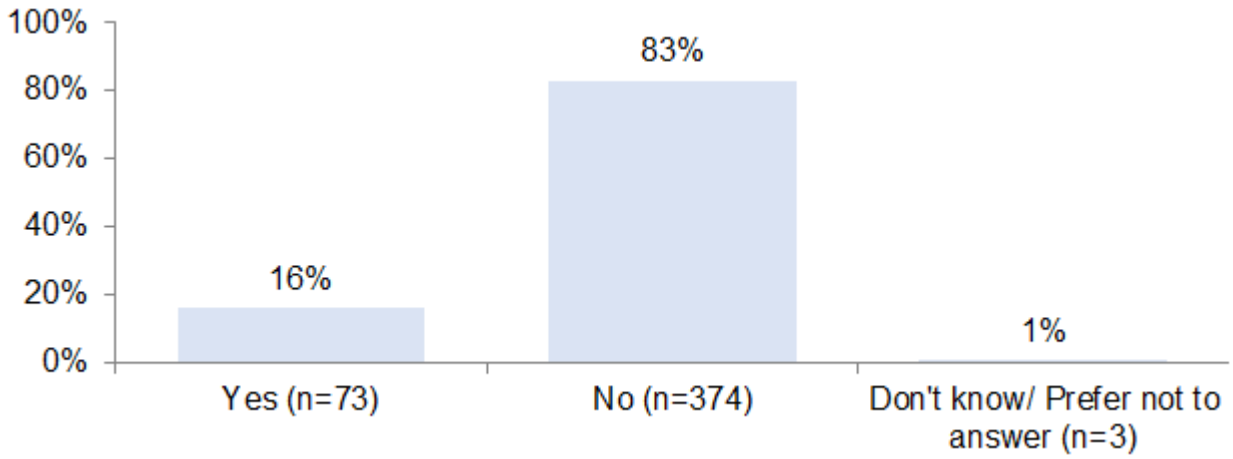

About three-quarters of individual respondents were born in Australia (73%), and a quarter were born overseas (26%).

Figure 7: Percentage of individual respondents, by whether born in Australia (n=450)



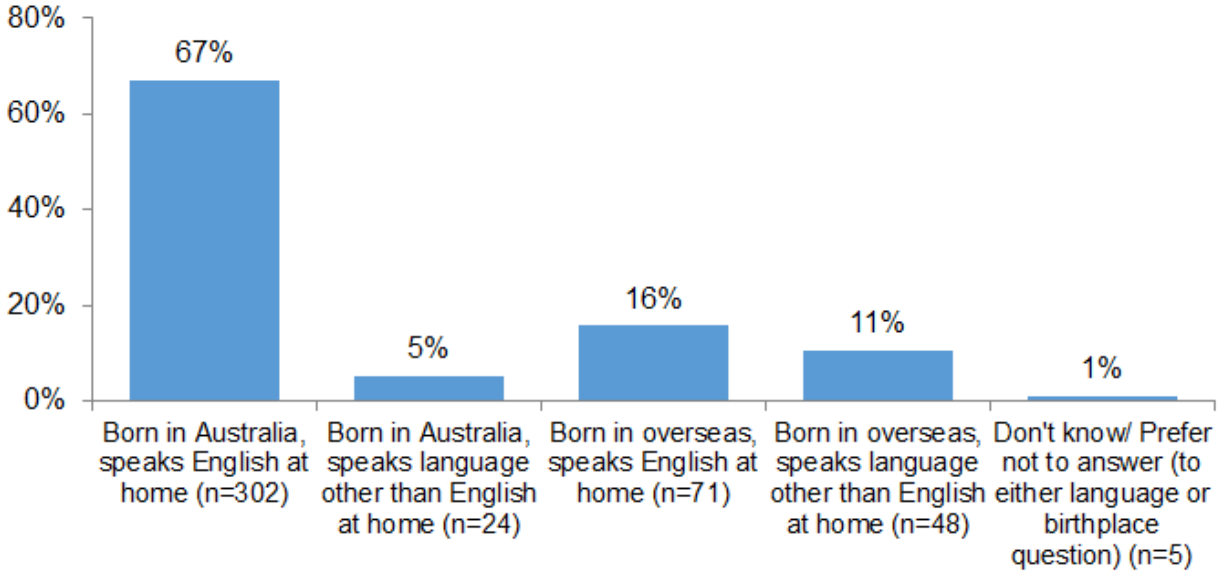

The vast majority of individual respondents spoke English at home (83%), with 16% saying they spoke a language other than English at home. (See Figure 8.)

Figure 8: Percentage of individual respondents, by whether speaks language other than English at home (n=450)




Four culturally and linguistically diverse (CALD) categories were determined, for the purposes of reporting, by combining respondents' answers about being born in Australia and speaking a language other than English at home.[5] As shown in Figure 9, 67% of individual respondents were born in Australia and spoke English at home, with 5% to 16% in the other three created CALD categories.

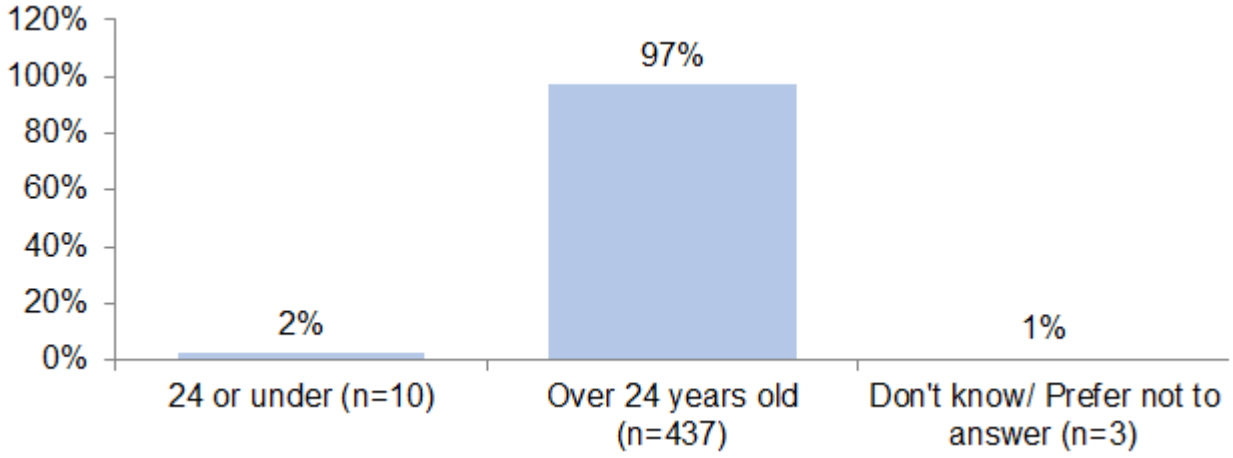
Figure 9: Percentage of individual respondents, by culturally and linguistically diverse categories (n=450)




[5] This approach to creating simplified CALD categories from the two binary variables is used in some Australian Bureau of Statistics (ABS) publications, for example, Cat. 4329.0.00.001 - *Cultural and Linguistic Characteristics of People Using Mental Health Services and Prescription Medications, 2011*, and Cat. 4250.0.55.001 - *Perspectives on Education and Training: Social Inclusion, 2009*.

Individual respondents were also asked whether they were aged 24 or under, or were over 24 years old. This was to identify "young people", a population segment that was targeted in one of the priority initiatives listed in the Ministerial Charter letter of 2016. (Addressed in Section 6, on page 135.) Ten respondents were young people, by the Ministry's classification of being 24 years old, or younger.

Figure 10: Percentage of individual respondents, by whether 24 years old or under, or older (n=450)




## 3.4 Reporting of findings

The responses to each individual question asked in the online consultation have been analysed and the findings are reported in this document in terms of the overall responses received to the particular question, and the findings for respondent segments formed from:

- remoteness category
- organisation types
- individual backgrounds
- Aboriginal/ not Aboriginal
- culturally and linguistically diverse (CALD) groups.

For introductory, high level reporting, two aggregated organisation segments were formed by combining NSW Health and Other NSW Government respondents into one segment called "NSW Government organisations", and all other organisation types into "Other organisations". For the same introductory reporting, two aggregated individual segments were formed by combining people with lived experience of mental illness with families and carers of people with a lived experience of mental illness, into one segment called "people with lived experience of mental illness and their families and carers", and all other individuals into "Health professionals and other individuals".

As mentioned in Section 3.3, and shown in Figure 2, very few submissions were received from respondents in the more remote areas of New South Wales, so the three very remote,

remote and outer regional categories were aggregated to one segment for analysis and reporting, and are referred to as "outer regional/ remote" throughout this report.

Organisation types are reported in segments formed directly from the questionnaire coding frame. The total number of submissions from respondents from the research/ university sector was low (n=7), as shown in Figure 3, in Section 3.3.1, which creates the potential for percentages for this segment to appear disproportionally high or low compared to other segments, with larger sample sizes. However, this segment was considered important to the Ministry of Health, and is included in the reporting, as its own segment. Caution should be employed when interpreting the results for the research/ university sector segment.

For individual segments, "member of the public" and "other professional" were combined to create the "other professional/ member of the public" segment for reporting. (See Figure 4, in Section 3.3.2 for the sample breakdown for individual backgrounds.)

Because it was anticipated that the sample sizes for Aboriginal, Torres Strait Islander, and Aboriginal and Torres Strait Islander respondents would be relatively small, the analysis was prepared with these three separate individual types aggregated into one segment: "Aboriginal and Torres Strait Islanders." As shown in Figure 6, in Section 3.3.2, no submissions were received from Torres Strait Islanders, or Aboriginal and Torres Strait Islanders, so the "Aboriginal and Torres Strait Islanders" segment actually only contained Aboriginal respondents.

Four CALD groups are used in reporting, created from two demographic questions, as described at the end of Section 3.3.2.

Statistical significance testing was run at the 95% confidence level between each segment and the collective total for all its counterpart segments (the base from which the segments were derived), so:

- the percentages for remoteness categories were tested against those for the total sample, overall (because the postcodes, from which remoteness categories were derived, were requested from all respondents)
- the percentages for organisation types were tested against those for organisations overall
- the percentages for the following were all tested against those for individuals overall:
    - individual backgrounds
    - gender
    - Aboriginal/ not Aboriginal
    - CALD.

Significantly different results are marked in the more detailed level segment graphs and tables in this report by asterisks after the percentage figures.[6]

Note that percentages in graphs and tables are rounded to the nearest integer and will occasionally not sum to 100%, in cases where this would be expected.

To summarise the responses for each open-ended question, a series of tables are included. These each list the three most frequently mentioned topics for each of the respondent segments being reported in the table. Where percentages are shown, but were not one of the top three top topics mentioned by the segment (shown because the topic was one of the top three for another segment in the same table), figures are displayed in smaller, paler grey font. (This is in case these figures are of comparative interest, and so that the table cells are not left empty.)

The open-ended summary tables are followed by some example verbatim quotes from respondents. One of the respondent's segments are shown in square brackets after each quote.[7] Verbatim quotes have not been specifically selected as examples for non-Aboriginal, or Australian born respondents who speak English at home, as these segments are largely synonymous with individuals overall, as their Aboriginal and other CALD segment counterparts have such small sample sizes by comparison.

The following sections of this report describe the findings from the online consultation survey.

[6] As proportional reporting of segments with vastly different sample sizes can be misleading, especially when very high or very low percentages are calculated from particularly small samples, significance testing is a good indicator of variations that are more likely to relate to segment trends than to chance.
[7] Multiple segments are not indicated in the square brackets, as many of the segments have small sample sizes and adding all segment details to quotes could potentially make individual respondents identifiable, through the combination of details.

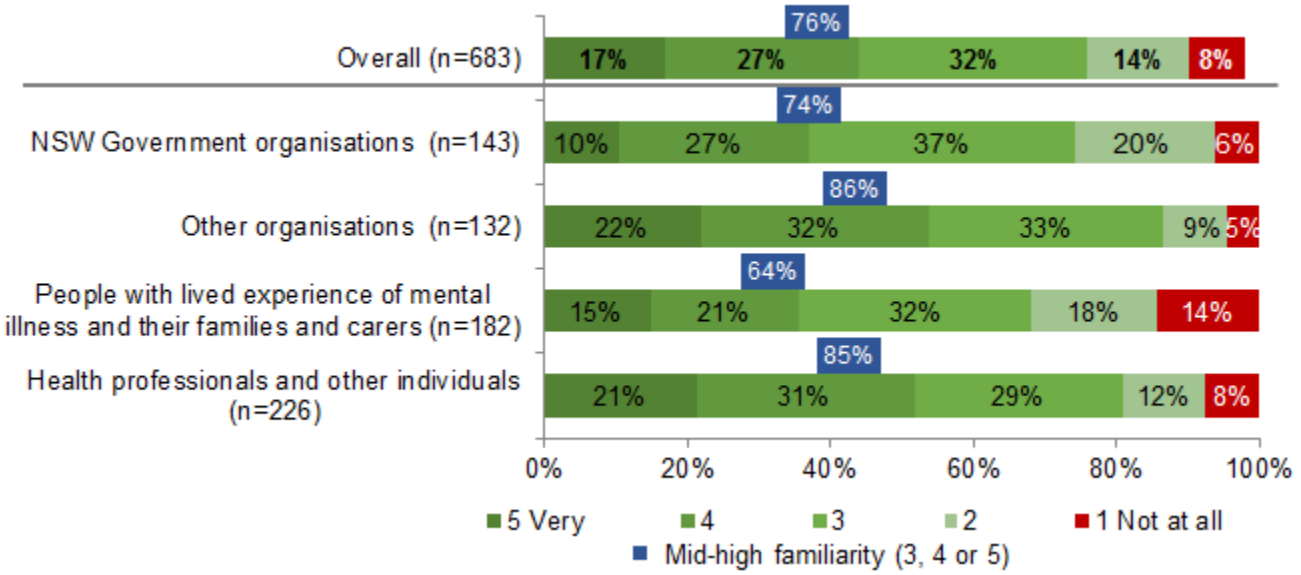
# 4 Familiarity with the work of the Mental Health Commission

Respondents were first asked to rate the extent of their familiarity with the work of the Mental Health Commission on a scale of 1 to 5, where 1 was 'Not at all' and 5 was 'Very'. As shown in Figure 11, about three quarters of the 683 respondents who answered this question had a mid to high level of familiarity, giving a rating of 3 to 5 (76%), while 8% indicated that they were not familiar with the Mental Health Commission's work.

Non-NSW Government organisations, and health professionals and other (non-consumer) individuals were most familiar with the Commission (86% and 85% had mid to high levels of familiarity, respectively), while people with lived experience of mental illness and their families and carers were least familiar (64% had mid to high levels of familiarity).

Throughout the online consultation results, a distinct pattern emerged of organisations being more positive than individuals about the Commission's work. Health professionals were generally the more positive of the individual segments, and people with a lived experience of mental illness were often least positive. Interestingly, consumers were also least familiar with the work of the Commission. This suggests that some lack of positively in people with a lived experience of mental illness may have been associated with lack of familiarity with the Commission's work, and that some of their responses, perhaps, were partly based on general assessments of their experiences with the mental health system more broadly, rather on familiarity with the Commission's work specifically.

Figure 11: Extent of familiarity with the work of the Commission, overall and by high level organisation and individual groupings (n=683).

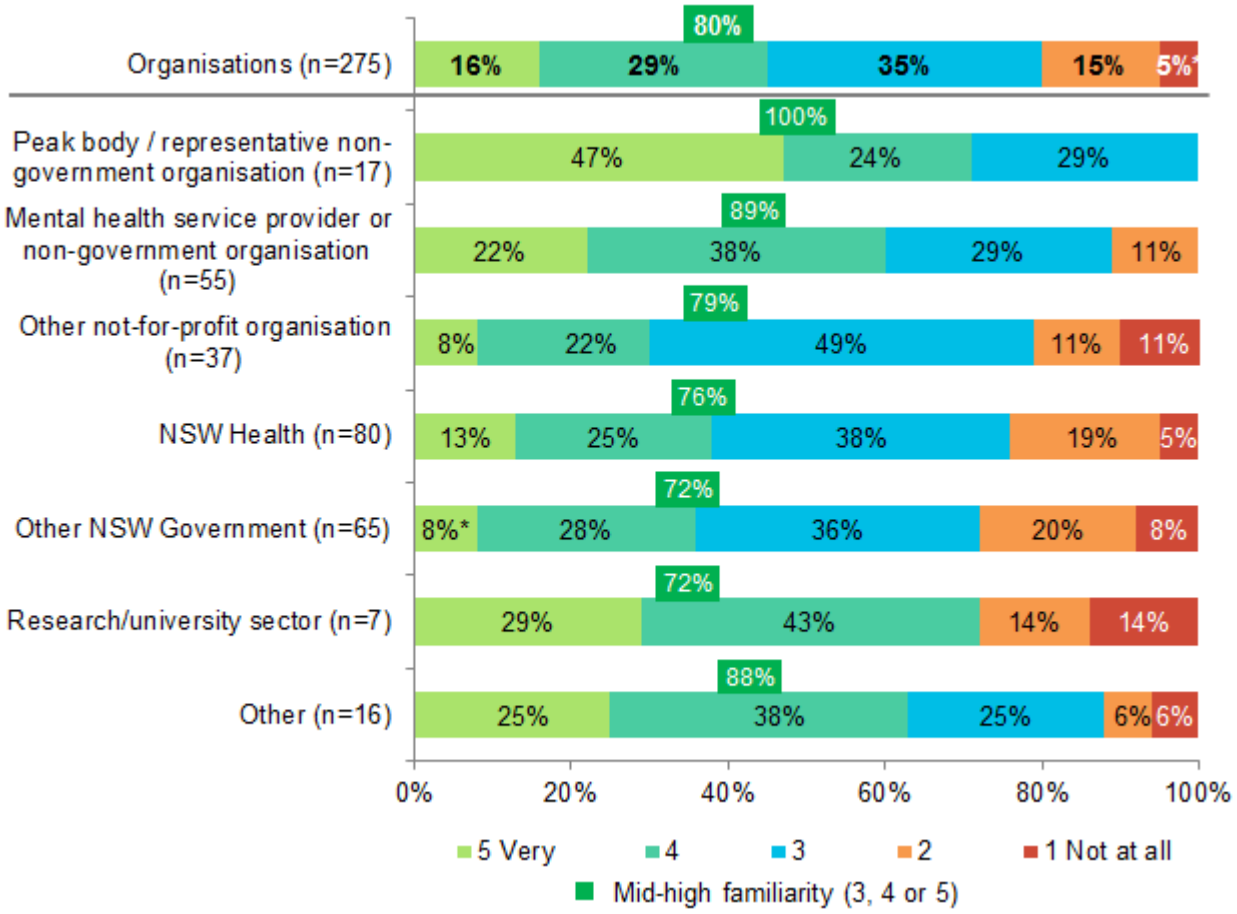



As shown in Figure 12 and Figure 13, individuals had a slightly lower mid to high level of familiarity than organisations (75% and 80% respectively), and were significantly more likely to be unfamiliar with the work of the Commission (11% of individuals gave a rating of 1).

Of the different types of organisations, peak bodies and representative non-government organisations were most familiar with the Commission's work (100% of the 17 gave a rating of 3 to 5), while Other NSW Government organisations, and the seven respondents from the research/university sector had the lowest levels of mid to high familiarity (72% each).[8] (See Figure 12.)

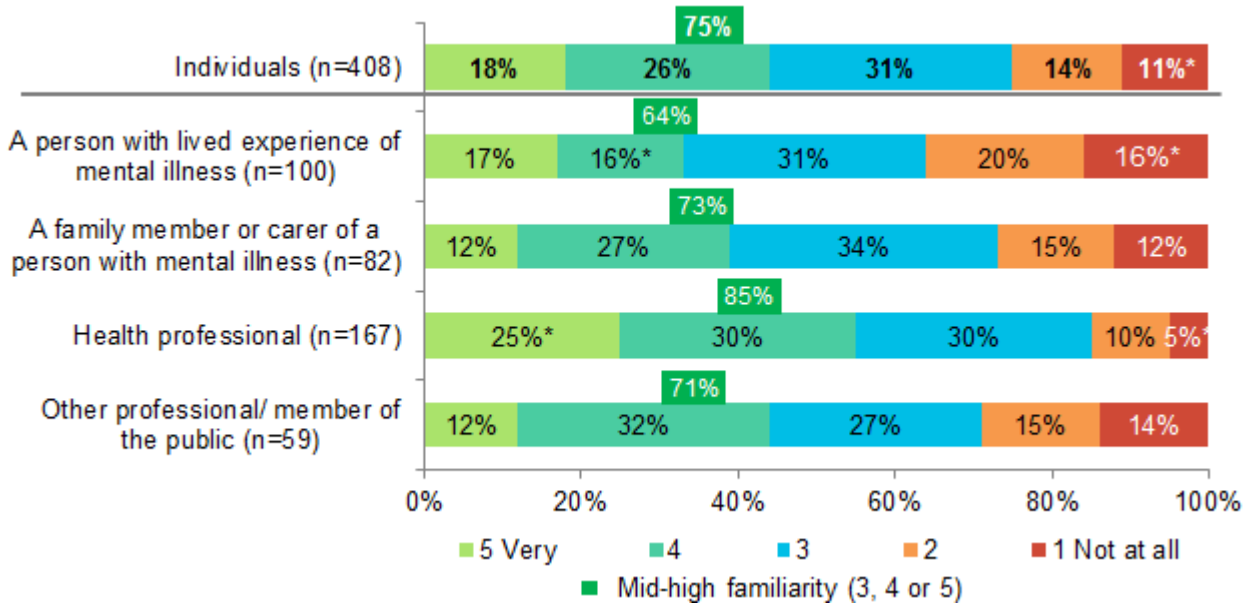
[8] Note that percentages for the research/university sector organisations are based on seven respondents only, so 72% represents five out of these seven respondents.

Figure 12: Organisations' extent of familiarity with the work of the Commission, overall and by organisation type (n=275)



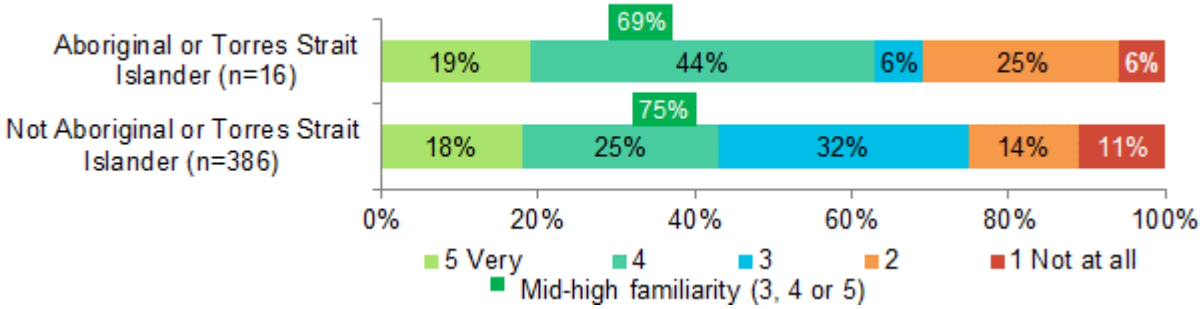

The individuals who were least familiar with the Commission's work were people with a lived experience of mental illness themselves. As shown in Figure 13, 64% of these individuals indicated that they had a mid to high level of familiarity with the Commission's work, and 16% said they were not familiar at all, which was significantly higher than the percentage of individuals who were unfamiliar overall (11%). In contrast, health professionals were the group of individuals with the highest mid to high level of familiarity (85%), and the significantly lowest proportion of individuals who were unfamiliar with the Commission's work (5%).

Figure 13: Individuals' extent of familiarity with the work of the Commission, overall and by individual background (n=408)



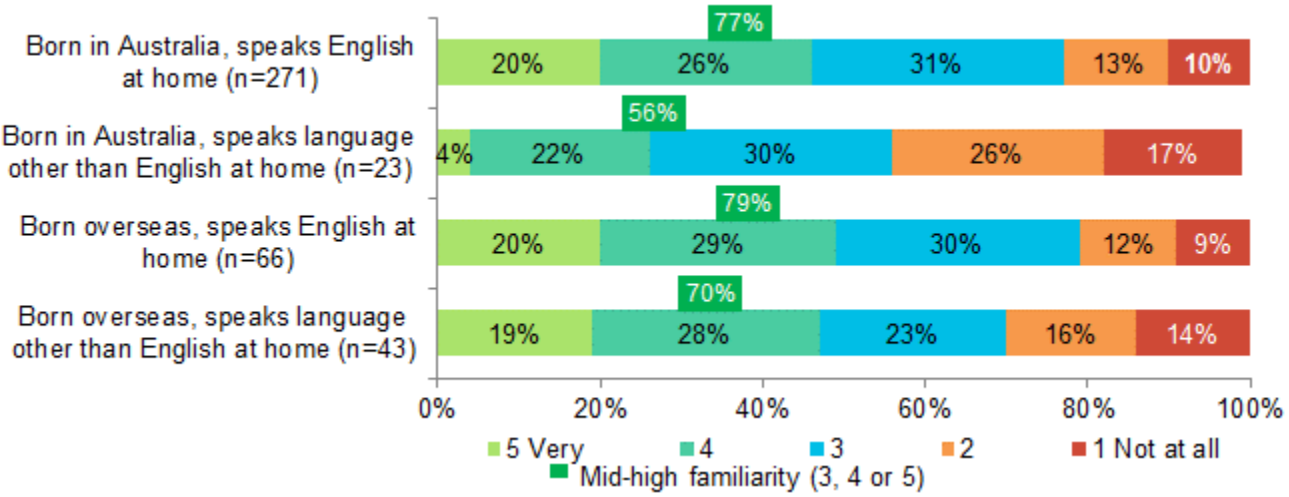

Aboriginal respondents had a slightly lower level of mid to high familiarity with the Commission's work than non-Aboriginal respondents (69% compared with 75%), but slightly fewer were actually unfamiliar (6% compared with 11%) (see Figure 14). Respondents who were born in Australia and spoke another language at home were the least likely culturally and linguistically diverse (CALD) group to be familiar with the Commission's work (56% mid to high familiarity, 17% unfamiliar), as shown in Figure 15. However, none of these differences were statistically significant.

Figure 14: Extent of familiarity with the work of the Commission, by Aboriginal and Torres Strait Islander origin (n=402)[9]



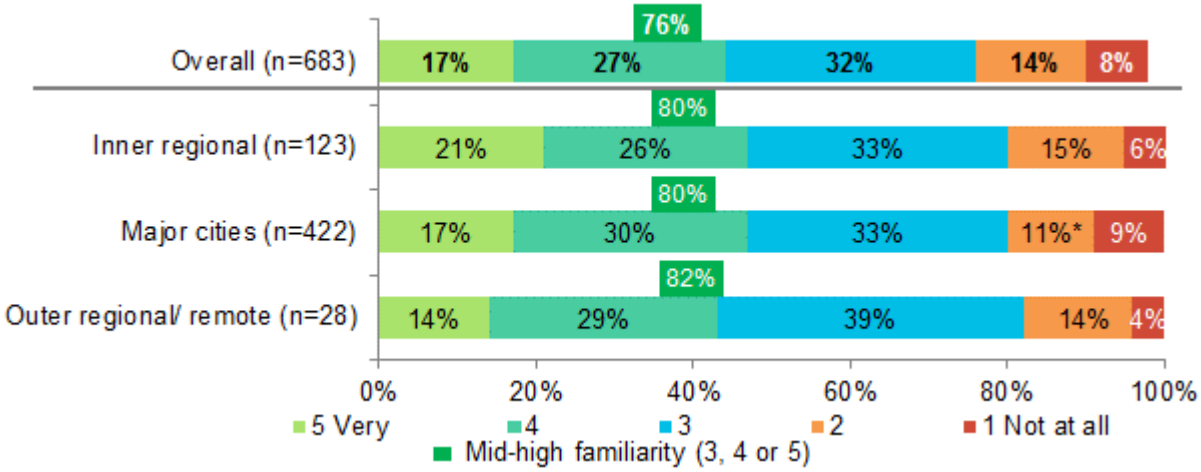

[9] No responses to the online consultation survey were received from Torres Strait Islanders; all Aboriginal or Torres Strait Islander respondents were Aboriginal.

Figure 15: Extent of familiarity with the work of the Commission, by culturally and linguistically diverse categories (n=403)




There was little variation in levels of familiarity between remoteness categories, as shown in Figure 16.

Figure 16: Extent of familiarity with the work of the Commission, overall and by remoteness category (n=683)



# 5 Functions under the Act

This section summarises the consultation feedback in relation to the Mental Health Commission's functions, as defined in 3.12.1 of the Act.

Between two-fifths and three-fifths of overall respondents agreed/ strongly agreed that the Commission had effectively undertaken each of the specified functions (41%-61%).

The function areas that respondents were most positive about were:

- the production of an effective strategic plan (61%)
- initiatives to educate the community about mental health issues (including to reduce the stigma and discrimination) (56%)
- policy development (53%)
- the advocacy and promotion of the general health and wellbeing of people who have a mental illness and their families (53%).

They were least positive about the Commission's role in reviewing and evaluating mental health and other services, programs and issues (41%), and in undertaking innovation (41%).

Organisations were consistently more positive than individuals about the Commission's work in its function areas, significantly so for all but three (the effectiveness of its research, and its innovation undertakings, and its education initiatives). Other organisations tended to be very slightly more positive that NSW Government organisations, with health professionals' levels just below both. Respondents with a lived experience of mental illness tended to be least positive of the individuals.

The general positivity about the effectiveness of the strategic plan stemmed predominantly from NSW Government organisations (69%) and other organisations (70%). Health professionals and other individuals were still positive (60%), but consumers and their families and carers were less so (46%). All groups were slightly less enthusiastic about how well the implementation of the Plan had been monitored and reported on, sometimes commenting that they could see no, or very little direct impact from it on the mental health sector. It was people with lived experience of mental illness and their families and carers who most often mentioned this perceived lack of impact, while organisations substantiated their positivity with what they considered to be effective outcomes of the Plan: for NSW Government organisations, this was often increased community awareness about mental health issues; and for other organisations, it was most often the greater empowerment and involvement of people with lived experience of mental illness.

NSW Government, other organisations, and health professionals[10] all, again, buoyed the positive results for the perceived effectiveness of the Commission's education initiatives and policy development, frequently commenting on the beneficial increases in community engagement, and occasionally naming specific initiatives.

In keeping with these favourable themes of increased community awareness and engagement, and the resulting empowerment and involvement of people with lived experience of mental illness, NSW Government and other organisations (and health professionals to a slightly lesser degree) were positive about the Commission having effectively fulfilled its functions to advocate and promote the general health and wellbeing of people who have a mental illness, and their families. The greatest impact of its advocacy and promotion activities were considered to be greater awareness and understanding of mental health issues.

Concerns around the lack of availability of mental health services, or timely access to such by those who need them, and perceptions that the Commission's work had had minimal impact on this situation, are likely to have contributed to the lower assessments of the effectiveness of the Commission's role in reviewing and evaluating mental health and other services, programs and issues and in undertaking innovation. These concerns were voiced most strongly by consumers themselves, who wanted impacts to be tangible when measured against their personal experiences.

## 5.1 The strategic plan

The first function the Act stipulated for the Commission was to prepare a strategic plan, and the second was to monitor and report on the implementation of this plan.

### 5.1.1 Drafting of the strategic plan

In regards to the requirements under the Act, and in reference to the plan, *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024*, and the implementation report *One Year On: Progress Report on the Implementation of Living Well*, respondents were asked to rate the extent of their agreement or disagreement with a statement that the Mental Health Commission had produced an effective strategic plan.

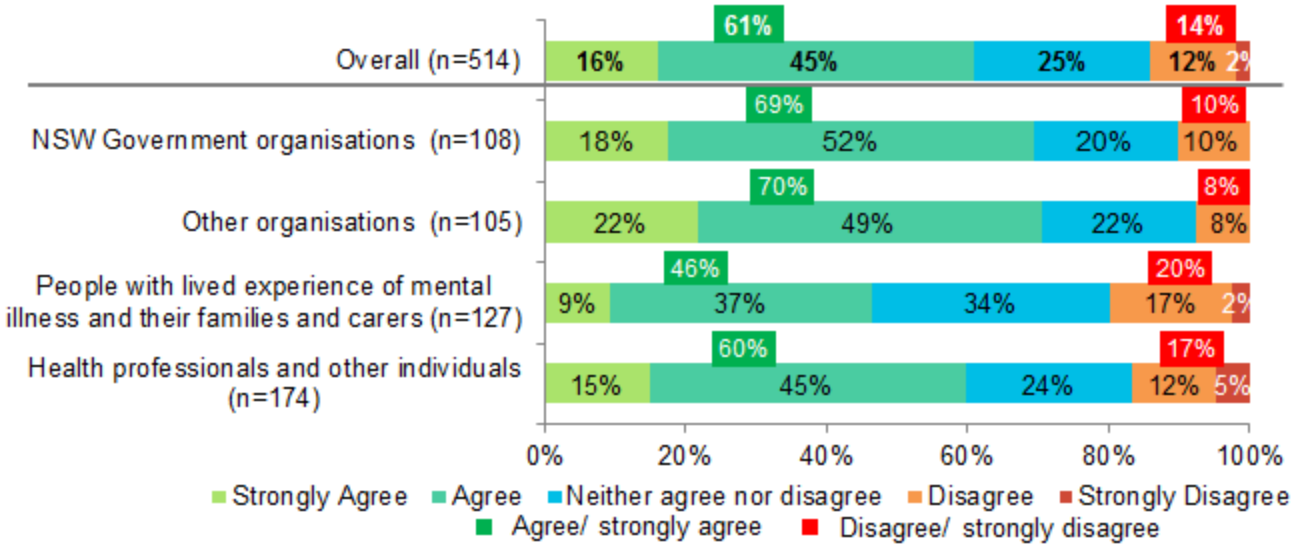
Sixty-one percent (61%) overall agreed/ strongly agreed that the Commission had produced an effective plan, as shown in Figure 17.

Submissions from NSW government organisations (69%) and other organisations (70%) were the most likely to believe that the Commission's strategic plan was effective; and

[10] Including individuals other than consumers and their families and carers.

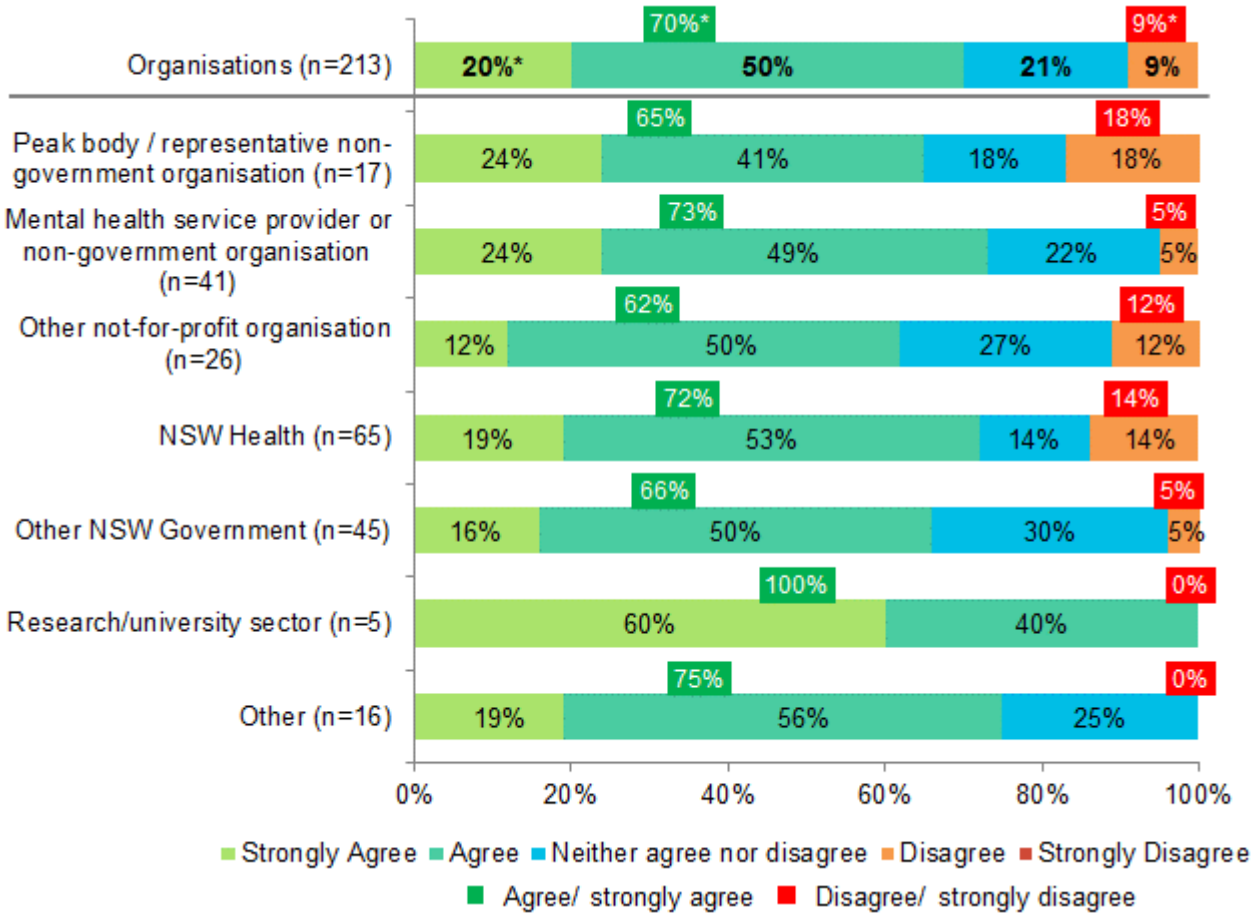
people with lived experience of mental illness and the carers were the least likely (46%). Submissions from the remaining group of individuals were positioned somewhere between the two (at 60%).

Figure 17: Level of agreement that the Commission *produced an effective strategic plan*, overall and by high level organisation and individual groupings (n=514)



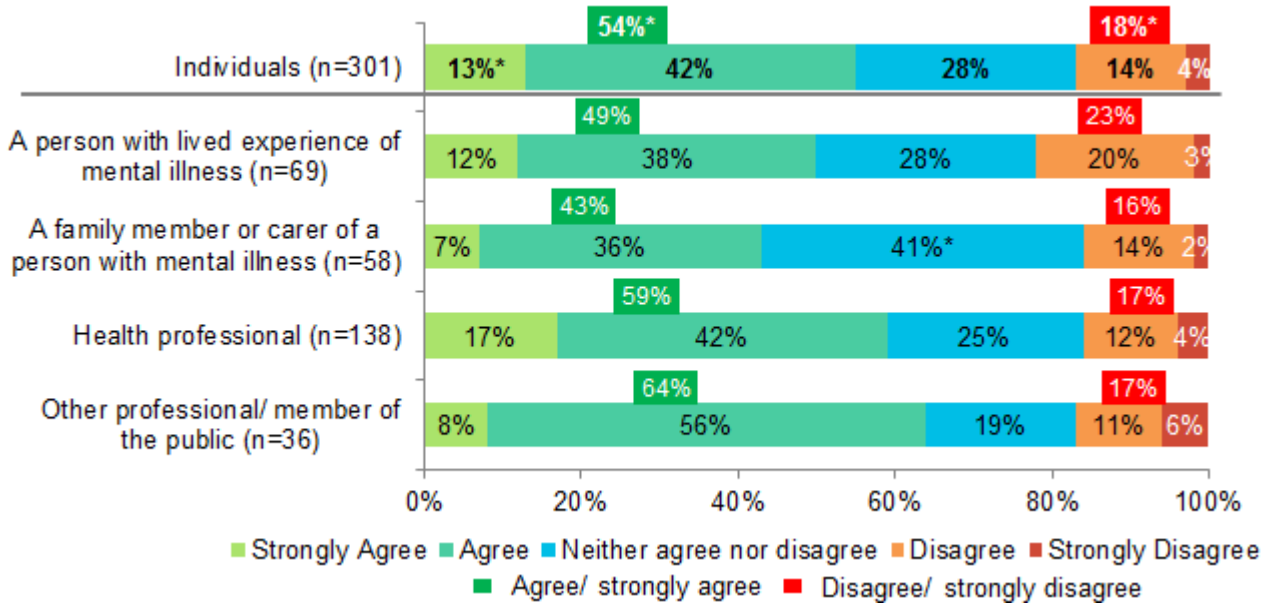
As shown in Figure 18, organisations had a significantly higher proportion of respondents who agreed with the statement (70%). Research/ university sector respondents displayed the highest levels of agreement to the statement (100%), although the difference between the findings for this segment and for organisations overall was not statistically significant, due to the low number of responses from this sector (n=5).

Figure 18: Organisations' level of agreement that the Commission *produced an effective strategic plan*, overall and by organisation type (n=213)



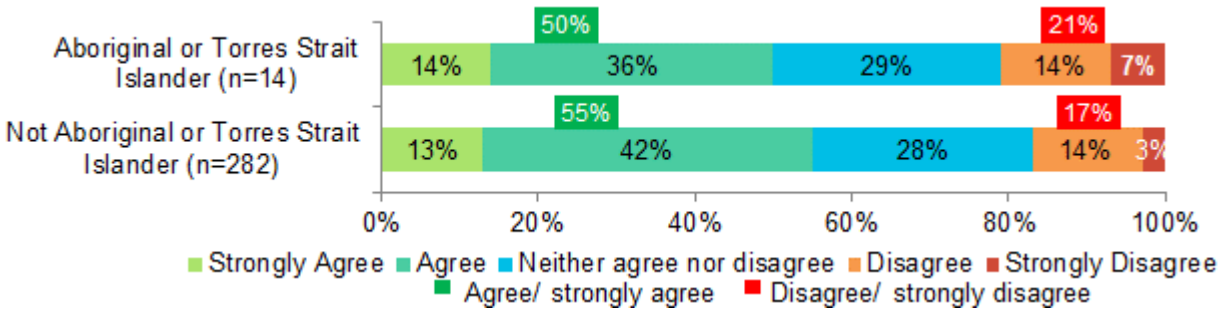

Individuals were significantly less likely than respondents overall to agree/ strongly agree to the statement, as shown in Figure 19. As previously stated, family members and carers of a person with mental illness were most in doubt of whether the Commission had produced an effective strategic plan, presenting the lowest agree/ strongly agree rate of individuals (43%), and a significantly higher proportion of respondents who neither agreed nor disagreed with this statement.

Figure 19: Individuals' level of agreement that the Commission *produced an effective strategic plan*, overall and by individual background (n=301)



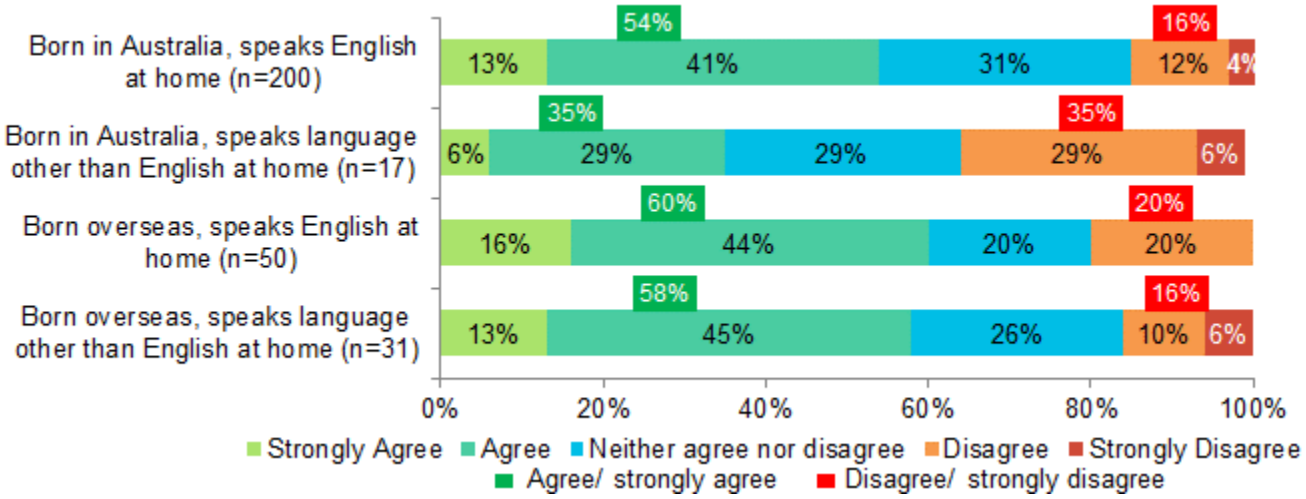

There were no significant differences in the agree/ strongly agree rates of Aboriginal and non-Aboriginal respondents, despite the rates for Aboriginal respondents being slightly lower (50% for Aboriginal respondents, 55% for non-Aboriginal respondents). (See Figure 20.)

Figure 20: Level of agreement that the Commission *produced an effective strategic plan*, by Aboriginal and Torres Strait Islander origin (n=296)



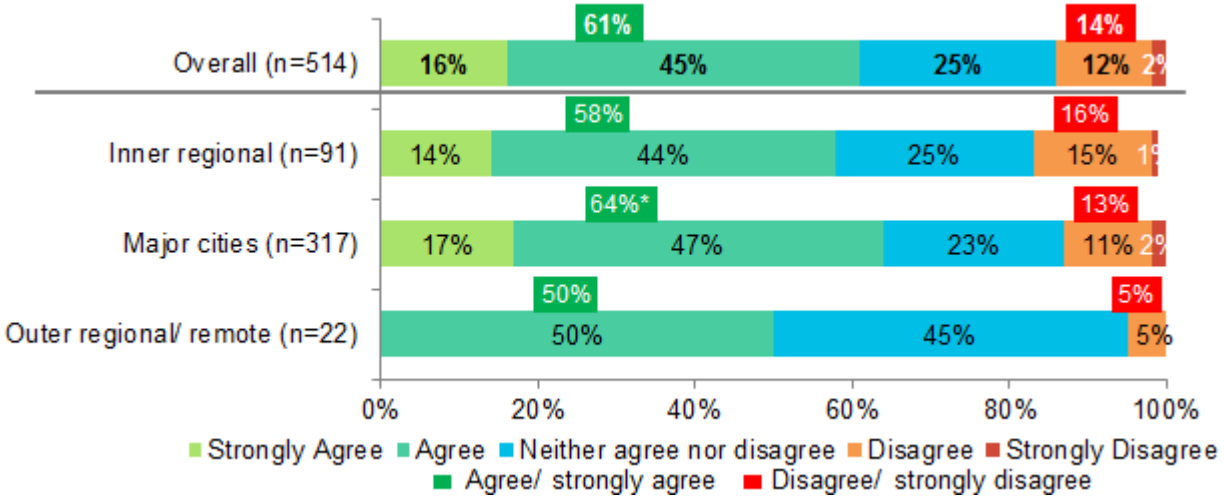

Respondents born in Australia, who spoke a language other than English at home recorded the lowest proportion of agree/ strongly agree for the statement (35% for the first), while those born overseas and speaking English at home were the most positive (60%). (See Figure 21.) Again, the differences between CALD segments were not statistically significant.

Figure 21: Level of agreement that the Commission *produced an effective strategic plan*, by culturally and linguistically diverse categories (n=298)




Respondents from major cities were significantly more likely than respondents from any regional or remote areas to agree/ strongly agree with the statement (64%).

Figure 22: Level of agreement that the Commission *produced an effective strategic plan*, overall and by remoteness category (n=514)




## 5.1.2 Monitoring of the strategic plan

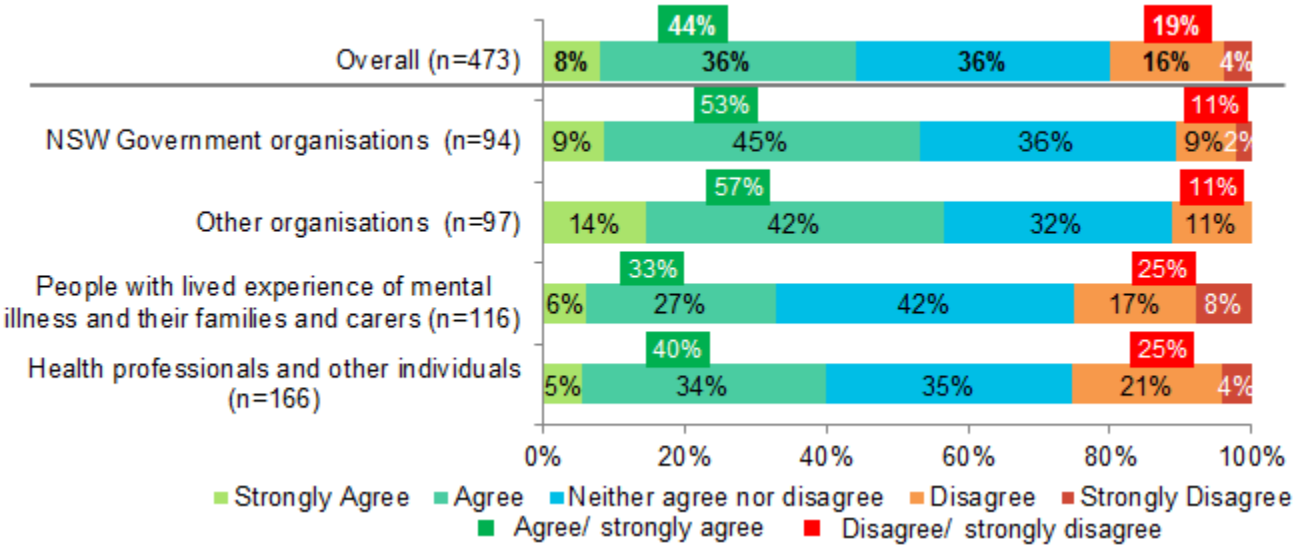
Still regarding the requirements under the Act, and in reference to the plan, *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024*, and the implementation report *One Year On: Progress Report on the Implementation of Living Well*, respondents were asked to rate the extent of their agreement or disagreement with the statements that the Mental

Health Commission had sufficiently monitored and reported on the implementation of the Plan.

Forty-four percent (44%) overall agreed/ strongly agreed that the Commission had sufficiently monitored and reported on the implementation of the Plan, as shown in Figure 23.

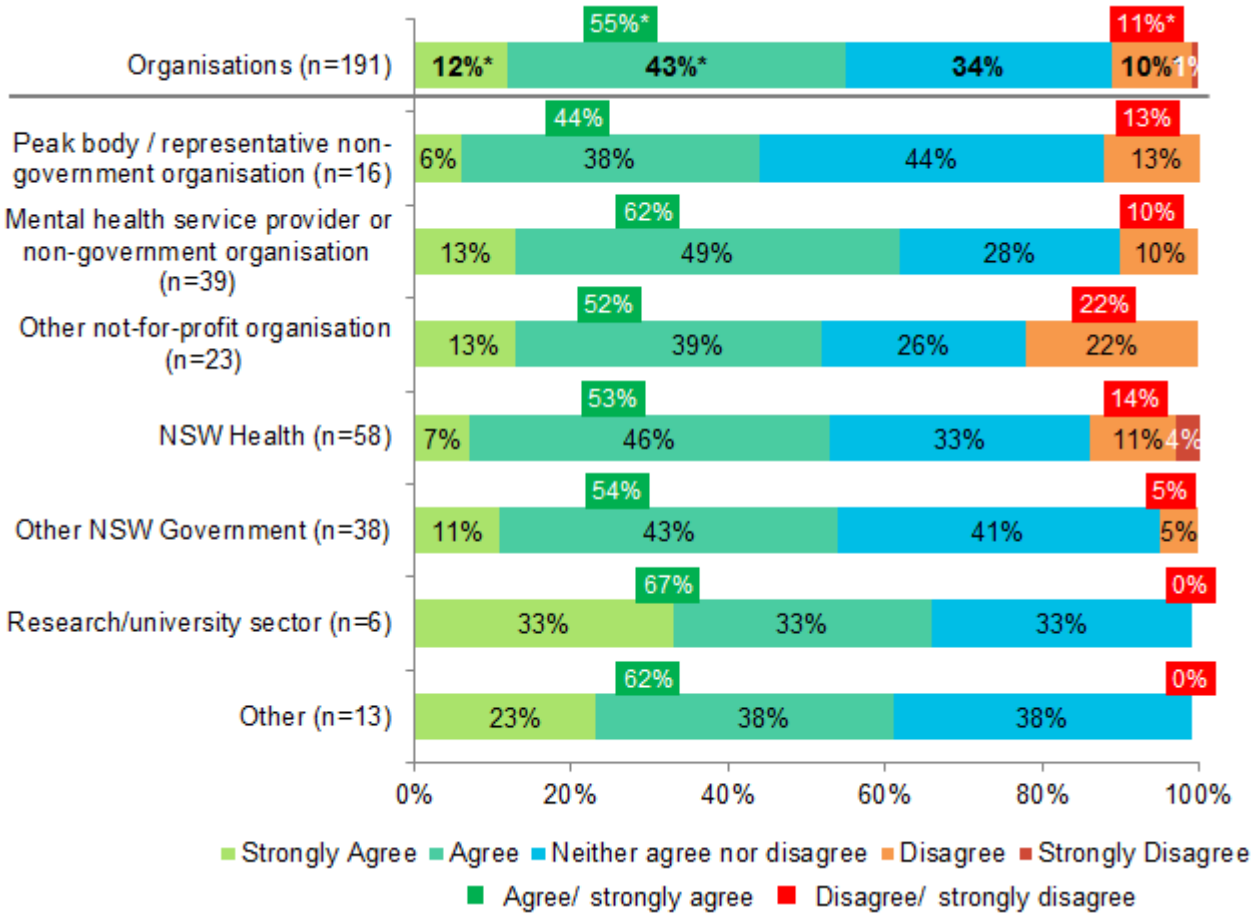
Whilst submissions were less positive about the way in which this strategic plan had been reported on that they were about its effectiveness, again NSW Government and other organisations were more positive (53% and 57% respectively) than individuals and their carers (33%); with health professionals and other individuals, again, somewhere in between (40%).

Figure 23: Level of agreement that the Commission *sufficiently monitored and reported on implementation of the Plan*, overall and by high level organisation and individual groupings (n=473)



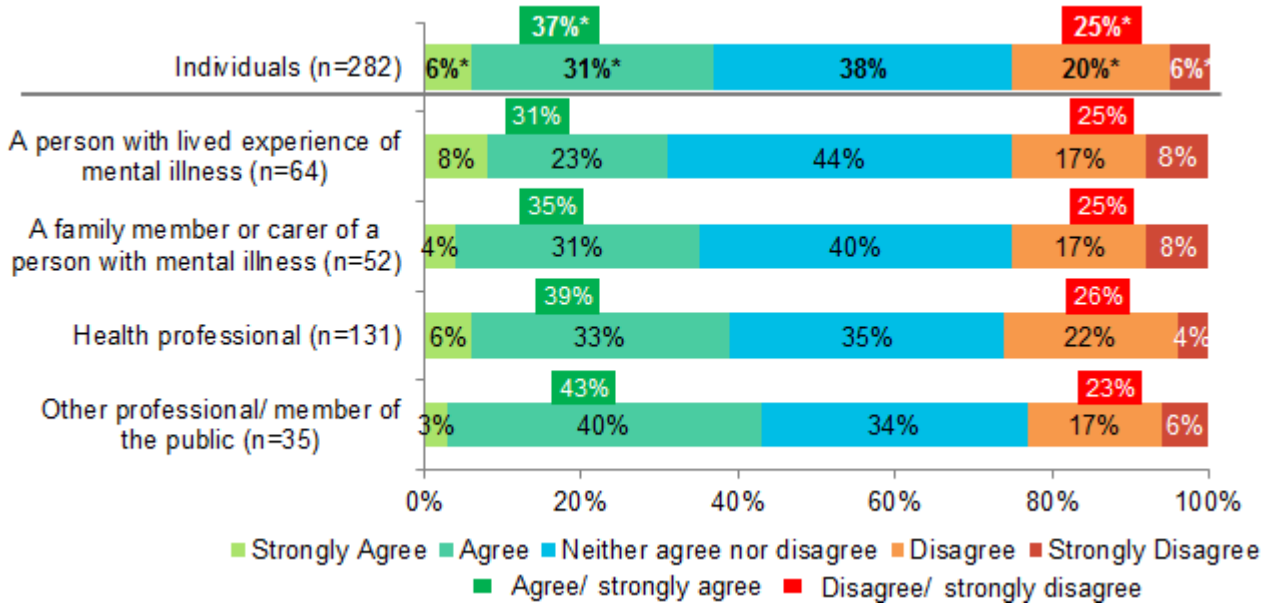
As shown in Figure 24, organisations had a significantly higher proportion of respondents who agreed with this statement (55%). Research/ university sector respondents, again, displayed the highest levels of agreement (67%), although the difference between the findings for this segment and for organisations overall was also not statistically significant, due to the low number of responses from this sector (n=6).

Figure 24: Organisations' level of agreement that the Commission *sufficiently monitored and reported on implementation of the Plan*, overall and by organisation type (n=191)



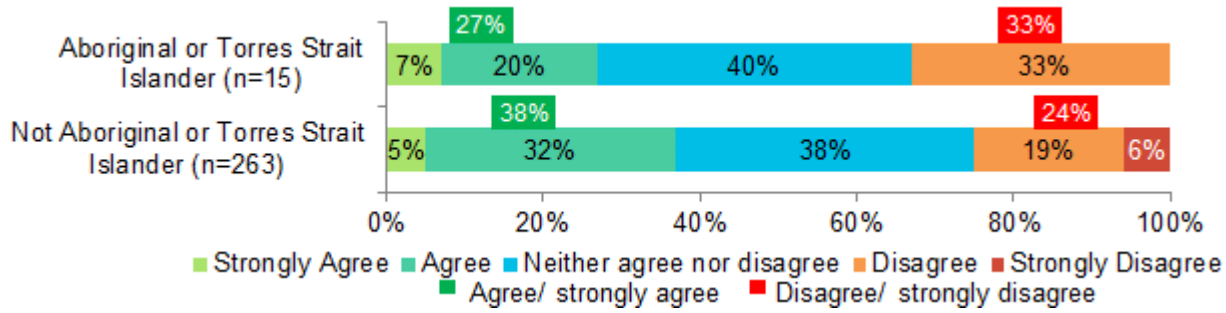

Individuals were significantly less likely than respondents overall to agree/ strongly agree to this statement, as shown in Figure 25. There was less variation between the attitudes of the various groups of individuals towards the statement about the Commission sufficiently monitoring and reporting on the implementation of the Plan, than there had been for it having produced an effective one.

Figure 25: Individuals' level of agreement that the Commission *sufficiently monitored and reported on implementation of the Plan*, overall and by individual background (n=282)



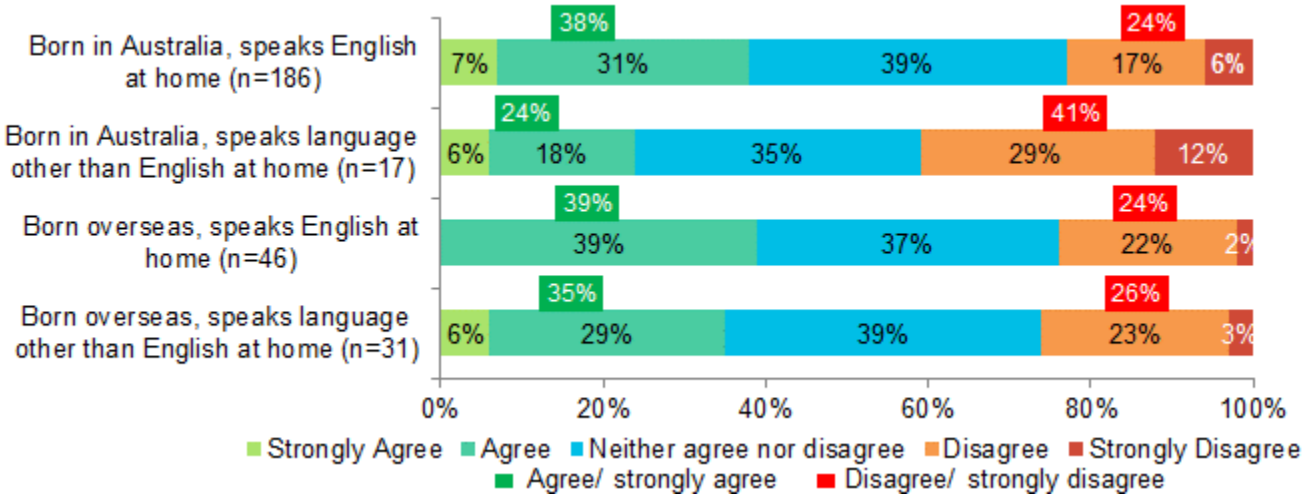

There were no significant differences in the agree/ strongly agree rates of Aboriginal and non-Aboriginal respondents, despite the rates for Aboriginal respondents being slightly lower for this statement, as well as the previous one (27% for Aboriginal respondents, 38% for non-Aboriginal respondents). (Figure 26.)

Figure 26: Level of agreement that the Commission *sufficiently monitored and reported on implementation of the Plan*, by Aboriginal and Torres Strait Islander origin (n=278)



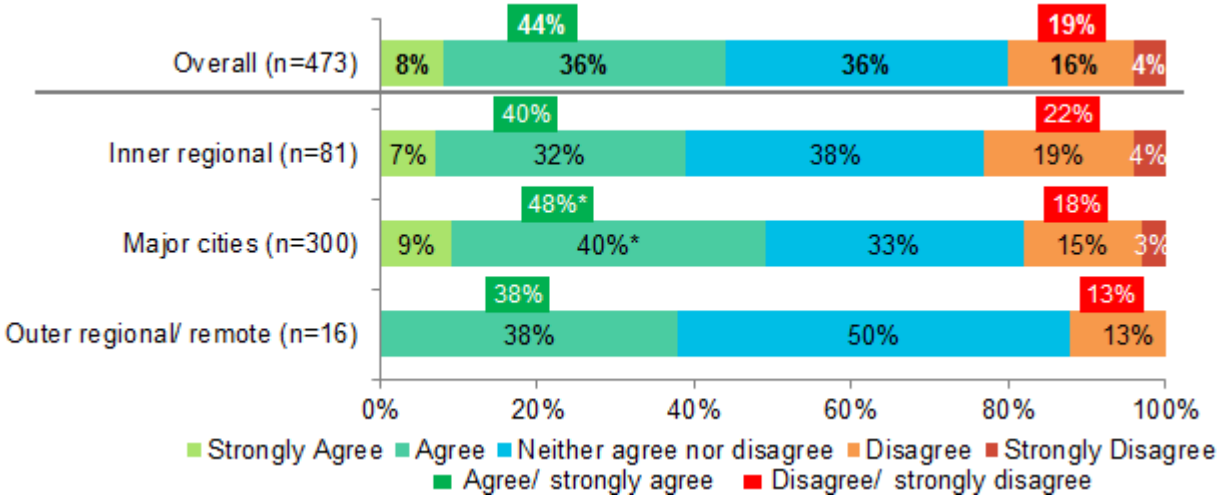

As with the statement about the effectiveness of the Plan, respondents born in Australia, who spoke a language other than English at home recorded the lowest proportions of agree/ strongly agree for this statement (24%), while those born overseas and speaking English at home were the most positive (39%). (See Figure 27.) Again, the differences between CALD segments were not statistically significant.

Figure 27: Level of agreement that the Commission *sufficiently monitored and reported on implementation of the Plan*, by culturally and linguistically diverse categories (n=280)




Respondents from major cities were significantly more likely than respondents from any regional or remote areas to agree/ strongly agree with this statement about the Commission having sufficiently monitored and reported on the Plan's implementation (48%).

Figure 28: Level of agreement that the Commission *sufficiently monitored and reported on implementation of the Plan*, overall and by remoteness category (n=473)



### 5.1.3 Impact of the strategic plan

Respondents who had supplied an agreement rating for either of the previous statements about the strategic plan were asked to say, in their own words, what impact they thought the strategic plan had had on the mental health system, and the mental health and wellbeing of the people of New South Wales. Table 4 lists the three most frequently mentioned topics given in responses to this question overall, and the three topics most frequently mentioned by each of the high level organisation and individual segments.[11]

Respondents did not say that the strategic plan had caused any negative impacts; however, there were few perceived positive effects. The most prevalent theme that emerged was that respondents had seen little impact on the mental health system or on the mental health and wellbeing of people of New South Wales, or that there had been some impact, but it was "not significant" or was "minimal" (15% of respondents). The most frequently mentioned positive effect was associated with a perceived increase in general community awareness and consideration of mental health issues (14%), although the same proportion of respondents raised issues around insufficient funding or resourcing for mental health services (14%).

NSW Government submissions were particularly likely to express that the Commission's strategic plan had increased awareness of mental health issues (27%); while individuals with lived experience of mental illness were most likely to say that the impact had been negligible (21%).

Table 4: Top three impacts of the strategic plan mentioned overall, and by high level organisation and individual groupings

| Topics | n= | Overall<br>316 | NSW Government organisations<br>67 | Other organisations<br>61 | People with lived experience of mental illness and their families and carers<br>73 | Health professionals and other individuals<br>115 |
|---|---|---|---|---|---|---|
| Limited/ little/ negligible | | 15% | 7% | 10% | 21% | 17% |

[11] Percentages displayed in smaller, paler grey font indicate that the topic was not in the segment's top three most frequently mentioned topics (but was in the top three for another segment included in the same table).

| Topics | n= | Overall 316 | NSW Government organisations 67 | Other organisations 61 | People with lived experience of mental illness and their families and carers 73 | Health professionals and other individuals 115 |
|---|---|---|---|---|---|---|
| Increased awareness/ profile of mental health | | 14% | 27% | 7% | 14% | 11% |
| Lack of funding/ resources | | 14% | 15% | 15% | 10% | 15% |
| Empowering/ involvement of people with lived experience | | 11% | 13% | 18% | 4% | 10% |
| Priorities/ objectives/ goals | | 9% | 13% | 15% | 7% | 4% |
| Barriers/ implementation issues | | 6% | 7% | 3% | 11% | 4% |
| Limited scope/ focus - favours LHDs over whole of MHI, etc. | | 7% | 3% | 8% | 11% | 5% |

Organisations were slightly more positive than individuals, and most often mentioned an increase in awareness about mental health (17%), and increased involvement of, and engagement with, people with a lived experience of mental illness (16%, which was significantly higher than for the overall sample). Funding and resourcing issues were still raised by 15% of organisations. There were no significant differences in the proportion of respondents from each organisation type who mentioned each topic (largely due to small sample sizes in some of the organisation segments); however, the range of most frequently mentioned topics for each organisation type can be seen in Table 5. Many types of organisations positively commented that the strategic plan had clarified objectives for the mental health system, and brought about a sense of direction (and accountability). This was the fourth most frequently mentioned topic for organisations overall (14%).

Table 5: Top three impacts of the strategic plan mentioned by organisations, overall and by organisation types[12]

| Topics | n= | Organisations overall[15] | Peak body / representative non-government orgs | Mental health service provider or non-gov org | NSW Health | Other NSW Government | Research/university sector | Other not-for-profit org | Other |
|---|---|---|---|---|---|---|---|---|---|
| | | 128 | 11 | 41 | 26 | 5 | 11 | 13 | |
| Increased awareness/ profile of mental health | | 17% | - | 5% | - | 17% | 42% | 40% | 8% |
| Empowering/ involvement of people with lived experience | | 16%* | 18% | 24% | - | 12% | 15% | 20% | 23% |
| Lack of funding/ resources | | 15% | 9% | 10% | 36% | 20% | 8% | - | 15% |
| Limited/ little/ negligible | | 9%* | 27% | 5% | - | 7% | 8% | - | 15% |
| Positive impact (general) | | 3% | - | 5% | - | - | 8% | - | 8% |
| Limited scope/ focus - favours LHDs over whole of MH, etc. | | 5% | 9% | 14% | 9% | 5% | - | - | - |
| Lacks whole of government approach/ support | | 2% | - | - | 18% | 2% | - | - | - |
| Particular groups left out | | 7% | 9% | 5% | 27% | 2% | 8% | - | 8% |
| Emphasis/ focus on recovery | | 5% | - | 5% | 9% | 5% | 8% | - | - |
| Priorities/ objectives/ goals | | 14%* | 18% | 10% | 9% | 20% | 4% | 40% | 15% |
| Improved care/ health outcomes | | 5% | - | 14% | - | 5% | - | 20% | - |

Some examples of verbatim comments provided by respondents include:

> *"Created increased focus and attention. Assisted with raising the profile."* [Other NSW Government]
>
> *"It broadened the scope of mental health as everyone's business."* [Other NSW Government]

[12] An asterisk in any organisation type column indicates that the difference between the finding for the segment and the finding for organisations overall is statistically significant.

*"Strong messaging about making individuals with lived experience central to all that is done."* [NSW Health]

*"Potentially, the impact could be great. However, it requires a higher level of commitment and funding from government to achieve this outcome and that has yet to happen."* [Mental health service provider or non-government organisation]

*"Very little, until the MHC is given some teeth*." [Peak body / representative non-government organisation]

*"Negligible."* [Peak body / representative non-government organisation]

*"It has empowered communities in relation to their mental health services."* [Peak body / representative non-government organisation]

*"It has provided a focus on individual mental health needs in the community."* [Peak body / representative non-government organisation]"

*"The strategic plan has been very effective in framing the terms of debate around mental health reform in NSW mental health services and in identifying the priorities and the principles that need to animate those reforms."* [Peak body / representative non-government organisation]

*"It has provided a significant blueprint for getting mental health services into communities."* [Peak body / representative non-government organisation]

*"Great commitment to wholistic care, physical health and a consumer perspective."* [Mental health service provider or non-government organisation]

*"The strategic plan gives a focus on empowering people to take control of their mental health issues."* [Mental health service provider or non-government organisation]

*"Significant but limited by the devolvement of decision making authority to LHDs."* [Mental health service provider or non-government organisation]

*"Reoriented mental health to a more positive health focus."* [Mental health service provider or non-government organisation]

*"Minimal impact. Although the Plan was solid and specific, the resources necessary to implement the Plan were not provided."* [NSW Health]

*"Aboriginal people that suffer mental health problems are not receiving culturally appropriate support, as there are limited workers in the field of mental health or none."* [NSW Health]

*"It has had an impact on reform planning, but it does not present a coherent and balanced agenda."* [NSW Health]

*"The strategic plan has supported reform undertaken in NSW public schools."* [Other NSW Government]

*"I see high needs in individuals with mental health issues that are not being met. Maybe no amount of resources would suffice, but resources are the key: enough nurses for example, enough service centres."* [Other NSW Government]

*"Raising the bar about MH issues."* [Other NSW Government]

*"Raised awareness in the community and government."* [Research/university sector]

*"I think it has attempted to change the focus from severe and enduring mental illness, to the full range of MH problems and contexts."* [Research/university sector]

*"It has been valuable in my sector for contributing to the seeding of mental health promotion programs and the evidence base behind the implementation of such programs."* [Research/university sector]

*"It has given guidance to organisations on how to provide better services based on the needs of the population."* [Other not-for-profit organisation]

*"It puts the consumer at the front."* [Other]

*"The government closed a lot of institutions and there is a major need to have better facilities opened again."* [Other]

*"Lacks impact."* [Other]

*"It has given clarity about the NSW MHC's vision for improving the mental health and wellbeing of the people of NSW."* [Other]

Significantly more individuals than organisations mentioned that the impact of the strategic plan had been limited or minimal (19%). Lack of sufficient funding and resourcing and a positive increase in awareness of mental health were the second and third topics most frequently mentioned by individuals, as listed in Table 6. People with a lived experience of mental illness were significantly more likely than other individuals to feel that there had been an increased focus on early intervention and, especially, more support provided for recovery (14%).

Table 6: Top three impacts of the strategic plan mentioned by individuals, overall and by individual background[13]

| Topics | n= | Individuals overall[15] | A person with lived experience of mental illness | A family member or carer of a person with mental illness | Health professional | Other professional/ member of the public |
|---|---|---|---|---|---|---|
| | | 188 | 36 | 37 | 97 | 18 |
| Limited/ little/ negligible | | 19%* | 22% | 19% | 19% | 11% |
| Lack of funding/ resources | | 13% | 8% | 11% | 16% | 6% |
| Increased awareness/ profile of mental health | | 12% | 11% | 16% | 10% | 17% |
| Positive impact (general) | | 3% | 3% | - | 2% | 11% |
| Negative impact (general) | | 9%* | 8% | 11% | 10% | - |
| Funding/ budgetary impacts | | 5% | - | 3% | 6% | 11% |
| Barriers/ implementation issues | | 7% | 11% | 11% | 3%* | 11% |
| Empowering/ involvement of people with lived experience | | 7%* | 6% | 3% | 9% | 11% |
| Limited scope/ focus - favours LHDs over whole of MH, etc. | | 7% | 14% | 8% | 5% | 6% |
| Emphasis/ focus on recovery | | 6% | 14%* | 5% | 4% | - |
| Priorities/ objectives/ goals | | 5%* | 3% | 11% | 4% | 6% |

Some examples of verbatim comments provided by respondents include:

> *"Not much change that helps individuals and families."* [A person with lived experience of mental illness]
>
> *"While the Plan is comprehensive and has great intentions, I am not sure how many policy or legislative changes have come out of it. I think it has only had a small impact."* [A person with lived experience of mental illness]

[13] An asterisk in any individual background segment column indicates that the difference between the finding for the segment and the finding for individuals overall is statistically significant.

*"The concept of mental health and wellbeing is a limited perspective and does not consider underlying barriers."* [A person with lived experience of mental illness]

*"It has certainly got recovery and peer work on the agenda."* [A person with lived experience of mental illness]

*"It has shifted the focus in NSW services to a focus on recovery and person-centred approaches."* [A person with lived experience of mental illness]

*"At this point, I've not seen any changes … I am still facing the same struggles and frustrations as I was years ago."* [A family member or carer of a person with mental illness]

*"It has created more awareness for the community and individuals to feel comfortable to talk about their struggles and seek help."* [A family member or carer of a person with mental illness]

*"People are more aware of mental health issues because of the Plan."* [A family member or carer of a person with mental illness]

*"More homes/care needed for ALL Australians, not just those on Centrelink payments."* [A family member or carer of a person with mental illness]

*"I think the ideas are great, but we have seen no change in our area. I think things are getting worse here."* [A family member or carer of a person with mental illness]

*"It has guided service development, but actual service quality is lagging badly."* [A family member or carer of a person with mental illness]

*"Accountability and a plan to work towards."* [A family member or carer of a person with mental illness]

*"The plan created some general goals that sought to influence the mental health community in NSW."* [A family member or carer of a person with mental illness]

*"The ideas in terms of what you would like implemented, are great, however… [with] limited staff, it's not feasible."* [Health professional]

*"The Plan was good, but there has been no financial or operational support to implement it."* [Health professional]

*"It gave mental health a more public face."* [Health professional]

*"Bugger all really; it is just more froth and bubble."* [Health professional]

*"No positive changes."* [Health professional]

*"Greater awareness."* [Other professional]

*"Focused attention on the broader definition of mental health and wellbeing … mental health is a community issue, not just a health issue."* [Other professional]

*"Like many of these plans, little real difference has been made."* [Other professional]

*"Great to have an independent focal point."* [Other professional]

*"Clearer priorities, increased funding in priority areas."* [Other professional]

*"Many parts of the Plan were not carried out, or implemented in unresourced, inappropriate or contrary ways. The Commission did not sufficiently monitor, report or hold NSW government agencies accountable for their lack of commitment and effort."* [Other professional]

*"The NSW Commission needs access to relevant data to be able to implement and monitor."* [Other professional]

*"I think it has been a really influential plan, particularly in relation to engagement of people with lived experience in policy and programming."* [Other professional]

Aboriginal respondents and non-Aboriginal respondents shared the same topics in their top three, with no significant differences in the percentage of mentions from each segment. They considered that:

- the impact of the strategic plan had been limited, or minimal (25% of Aboriginal respondents (two of eight), 19% of non-Aboriginal respondents)
- there was insufficient funding or resourcing within the mental health system (25% of Aboriginal respondents (two of eight), 12% of non-aboriginal respondents)
- awareness of mental health had increased (13% of Aboriginal respondents (two of eight), 12% of non-Aboriginal respondents)).

Table 7: Top three impacts of the strategic plan, by Aboriginal and Torres Strait Islander origin[14]

| Topics n= | Aboriginal 8 | Not Aboriginal 177 |
|---|---|---|
| Limited/ little/ negligible | 25% | 19% |
| Lack of funding/ resources | 25% | 12% |
| Increased awareness/ profile of mental health | 13% | 12% |

[14] An asterisk in any column in this table indicates that the difference between the finding for the segment and the finding for individuals overall is statistically significant.

| Topics n= | Aboriginal 8 | Not Aboriginal 177 |
|---|---|---|
| Negative impact (general) | 13% | 8% |
| Funding/ budgetary impacts | 13% | 5% |
| Variable - metro vs state-wide/ not state-wide | - | 4% |
| Limited scope/ focus - favours LHDs over whole of MH, etc. | 13% | 7% |

Some examples of verbatim comments provided by respondents include:

ABORIGINAL AND TORRES STRAIT ISLANDERS:

*"The impact has been limited."* [Aboriginal]

*"Mental health systems are overwhelmed, leading to poor outcomes and long waiting times for those in need of assistance."* [Aboriginal]

*"Mental health has become, by and large, now more acceptable, but still faces the challenges of stigma for those seeking services."* [Aboriginal]

*"Increasing funding for supports delivered in the community."* [Aboriginal]

*"With the introduction of NDIS, we have a situation where, due to the lack of consideration regarding the impact of the NDIS, a crisis has developed."* [Aboriginal]

The topics most frequently mentioned by respondents from each of the CALD categories are listed in Table 8. Again, there were no significant differences in the findings, although higher proportions of respondents born overseas than those born in Australia mentioned that they thought people with a lived experience of mental illness were now more empowered and less likely to feel social excluded (15% of those born overseas, speaking English at home, 11% of those born overseas speaking a language other than English at home).

Table 8: Top three impacts of the strategic plan, by culturally and linguistically diverse categories[14]

| Topics | n= | Born in Australia, speaks English at home | Born in Australia, speaks language other than English at home | Born overseas, speaks English at home | Born overseas, speaks language other than English at home |
|---|---|---|---|---|---|
| | | 126 | 7 | 33 | 19 |
| Limited/ little/ negligible | | 20% | 29% | 21% | 5% |
| Increased awareness/ profile of mental health | | 13% | 14% | 9% | 16% |
| Lack of funding/ resources | | 13% | 14% | 12% | 5% |
| Positive impact (general) | | 2% | - | 3% | 11% |
| Negative impact (general) | | 8% | 29% | 9% | 5% |
| Barriers/ implementation issues | | 7% | 14% | 3% | 11% |
| Empowering/ involvement of people with lived experience | | 6% | - | 15% | 11% |
| Limited scope/ focus - favours LHDs over whole of MH, etc. | | 9% | 29% | - | 5% |
| Emphasis/ focus on recovery | | 6% | - | 6% | 11% |
| Priorities/ objectives/ goals | | 4% | - | 12% | 5% |
| Improved care/ health outcomes | | 2% | - | - | 11% |

Some examples of verbatim comments provided by respondents include:

*"Very little change."* [Born in Australia, Speaks language other than English at home]

*"I am not sure it has had an impact on the wellbeing of the people of NSW."* [Born in Australia, Speaks language other than English at home]

*"It has given way more transparency. Other than that, not much has changed in mental health and it is perhaps in even worse shape than before with the debacle that is the NDIS."* [Born in Australia, Speaks language other than English at home]

*"No positive changes."* [Born in Australia, Speaks language other than English at home]

*"Need stronger drivers/influence onto the LHDs."* [Born in Australia, Speaks language other than English at home]

*"Minimal, as the distribution of funding does not create a functional and therapeutic environment in the community which can promote autonomy and Independence for its clients."* [Born overseas, Speaks English at home]

*"Very little impact at all."* [Born overseas, Speaks English at home]

*"It has given consumers, families and carers a voice."* [Born overseas, Speaks English at home]

*"I think it has had a very positive impact in influencing change and bringing greater focus to those with a lived experience [of mental illness] contributing."* [Born overseas, Speaks English at home]

*"Not enough staff for mental health services in Community Mental Health Areas."* [Born overseas, Speaks English at home]

*"Mental health departments are getting worse: less caring, over-worked and understaffed."* [Born overseas, Speaks English at home]

*"I believe the Strategic Plan has ensured that objectives are clear AND that they are consistently monitored and reviewed."* [Born overseas, Speaks English at home]

*""It has given a focus to the work of people in the sector; service planning initiatives refer to it as providing an overview of what NSW wants to do for mental health and it is used as a justification for initiatives that are recovery and community-oriented."* [Born overseas, Speaks English at home]

*"Increased some level of awareness in the community about mental health."* [Born overseas, Speaks language other than English at home]

*"I believe it has empowered people with a lived experience of mental illness and has helped raise awareness and lower stigma."* [Born overseas, Speaks language other than English at home]

*"Good, but more needs to be done for consumers and the wider community."* [Born overseas, Speaks language other than English at home]

*"It has had a great impact on mental health services incorporating physical health."* [Born overseas, Speaks language other than English at home]

*"I think the Strategic MH Plan was necessary, but I am not so sure that some things have improved. There are numerous issues with the MH Helpline, as it takes so long*

*to get through, if you get through at all. It is not uncommon to have to wait for an hour and you are still not attended to."* [Born overseas, Speaks language other than English at home]

*"Focus on community managed organisations, so that there is more support for prevention and early recovery."* [Born overseas, Speaks language other than English at home]

*"Better provision of care and health outcomes."* [Born overseas, Speaks language other than English at home]

*"It has had an impact on the mental health and wellbeing of migrants who are not proficient in English and who do not understand their own rights."* [Born overseas, Speaks language other than English at home]

A positive effect on community awareness of mental health issues was mentioned significantly more often by respondents in major cities (18%), who also quite frequently mentioned another positive effect: that the strategic plan had helped to reduce social stigma and empower people with lived experience of mental illness and increase their social inclusion (12%). Respondents from inner regional areas were a little more likely than respondents from other remoteness categories to mention the issues around inadequate funding or resourcing (but not significantly so) (20%). A couple of outer regional/ remote respondents were generally positive, indicating that the impact was "beginning to make a difference" (14%), but a couple expressed concerns that any impact had been limited in regional or rural areas, or for particular local groups, such as CALD communities (14% each).

Table 9: Top three impacts of the strategic plan, overall and by remoteness category

| Topics | n= | Overall | Major cities[15] | Inner regional[15] | Outer regional / remote[15] |
|---|---|---|---|---|---|
| | | 316 | 207 | 56 | 14 |
| Limited/ little/ negligible | | 15% | 14% | 16% | 14% |
| Increased awareness/ profile of mental health | | 14% | 18%* | 9% | 7% |
| Lack of funding/ resources | | 14% | 11% | 20% | 14% |
| Variable - metro vs state-wide/ not state-wide | | 3% | 3% | 4% | 14% |

[15] An asterisk in this column indicates that the difference between the finding for the segment and the finding overall is statistically significant.

| Topics | n= | Overall | Major cities[15] | Inner regional[15] | Outer regional / remote[15] |
|---|---|---|---|---|---|
| | | 316 | 207 | 56 | 14 |
| Particular groups left out | | 5% | 4% | 7% | 14% |
| Empowering/ involvement of people with lived experience | | 11% | 12% | 7% | 7% |
| Positive impact (general) | | 3% | 2% | 4% | 14% |

Some examples of verbatim comments provided by respondents include:

MAJOR CITIES

*"Increased the level of awareness in the community about mental health."* [Other professional]

*"Mental health is discussed more in the mainstream media, at work and school. I feel this a great outcome for the people of NSW."* [A person with lived experience of mental illness]

*"Impact has been limited."* [Mental health service provider or non-government organisation]

*"Mental health is going backwards. There has been no new funding for acute and emergency services for drastic increase in demand, leading to service demoralisation."* [NSW Health]

*"The mental health systems are overwhelmed, leading to poor outcomes and long waiting times for those in need of assistance."* [A family member or carer of a person with mental illness]

INNER REGIONAL

*"Services are inadequately funded by the Ministry for Health; there are too few frontline social workers … or Aboriginal Health Workers."* [Health professional]

*"The mental health departments are getting worse… less caring, over-worked and understaffed."* [A person with lived experience of mental illness]

*"Minimal, if any."* [Health professional]

*"Very little impact at all."* [Member of the public (none of the above)]

*"I think it has attempted to change the focus from severe and enduring MI to the full range of MH problems and contexts."* [Research/university sector]

*"It has raised awareness and responses to mental health. It has put it on the agenda and opened communications around mental health."* [Other NSW Government]

OUTER REGIONAL/ REMOTE

*"I haven't seen any effects or outcomes at my level."* [Health professional]

*"Still not enough money or resources for mental health in NSW, in particular, clinical psychologists in regional areas."* [A family member or carer of a person with mental illness]

*"In rural areas, there have been very few, (if any) changes arising from the strategic place due to several factors: insufficiently trained staff and medical professionals, under-resourced facilities and the ongoing prevalence of the medical model when managing mental health issues."* [Health professional]

*"There are still limited services to CALD communities, due to being rural."* [Mental health service provider or non-government organisation]

*"Not enough in rural areas."* [Health professional]

*"The mental health and wellbeing of regional people has deteriorated. Significant drug and alcohol issues, as well as major mental illnesses, are more prevalent and have a significant impact on the local fabric of society."* [Health professional]

*"Raised awareness in communities."* [Health professional]

## 5.2 Mental health services and programs

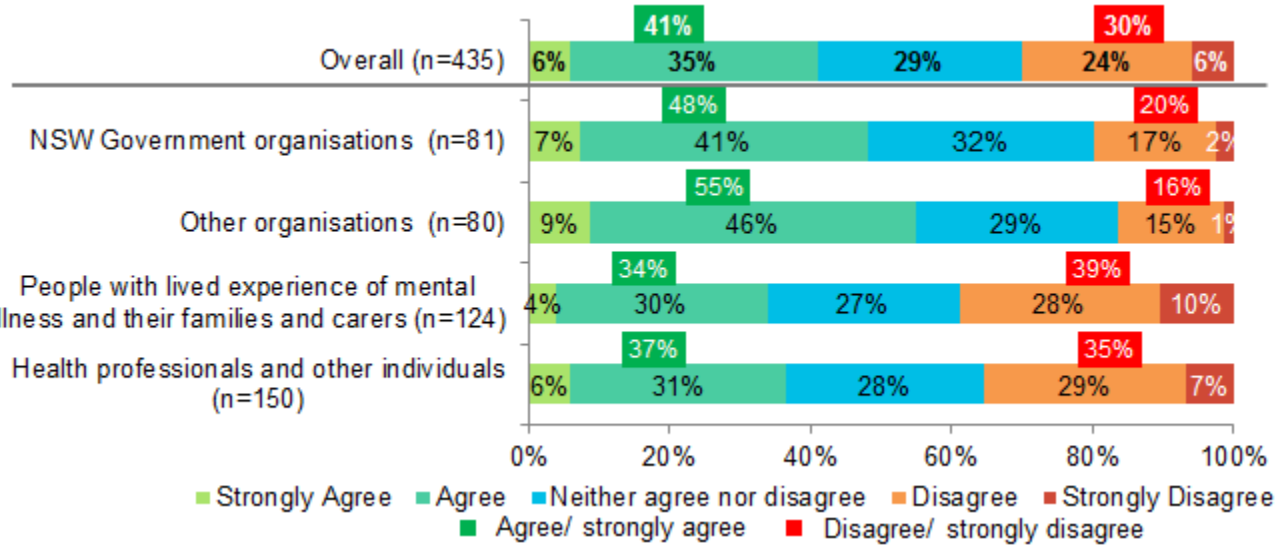
The third function defined by the Act was for the Mental Health Commission to *review and evaluate, and report and advise on, mental health services and other services and programs provided to people who have a mental illness, and other issues affecting people who have a mental illness*.

### 5.2.1 Reviewing, evaluating, reporting and advising on mental health services and programs

Forty-one percent of respondents agreed/ strongly agreed that the Commission had effectively reviewed and evaluated mental health and other services, programs and issues (41%). NSW Government organisations and other organisations were the most likely to

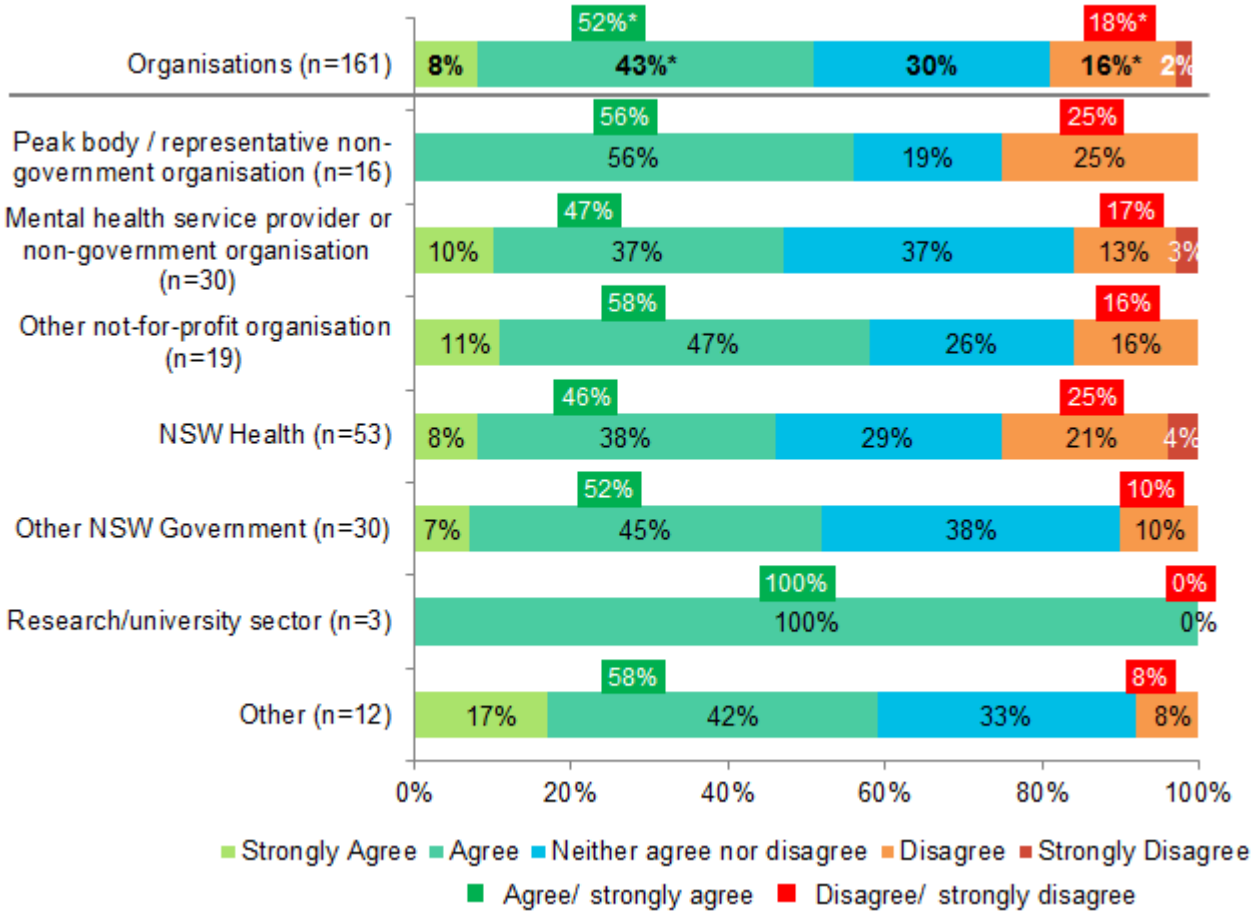
endorse this statement (48% and 55% respectively). People with lived experience of mental illness and their carers (34%) and the remaining group of individuals (including health professionals) were less likely (37%) to endorse the Commission's review and evaluation work.

Figure 29: Level of agreement that the Commission effectively *reviewed and evaluated mental health and other services, programs and issues*, overall and by high level organisation and individual groupings (n=435)




Organisations were significantly more positive than individuals about the effectiveness of the Commission in this area, as shown in Figure 30. Fifty-two percent agreed/ strongly agreed that the *reviewing and evaluating* work had been effective (52%). There were no statistically significant differences between the agreement levels of each organisation type.

Figure 30: Organisations' level of agreement that the Commission effectively *reviewed and evaluated mental health and other services, programs and issues*, overall and by organisation type (n=161)[16]

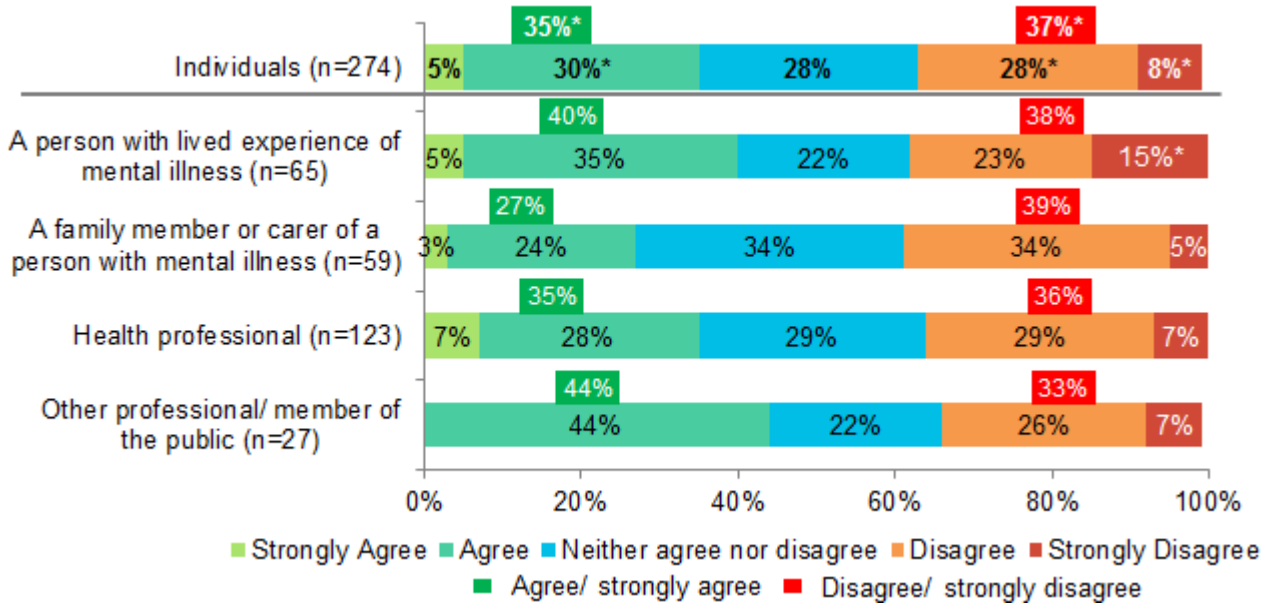



Close to a third (35%) of individuals agreed/ strongly agreed that the Commission's had effectively reviewed mental health services and programs provided to people who have a mental illness.

People with lived experience of mental illness were most likely to strongly disagree that the Commission had effectively reviewed and evaluated the services, programs and issues (15%),[17] but family members or carers had the lowest (but not significantly different) agree/ strongly agree rates (27%). (See Figure 31.)

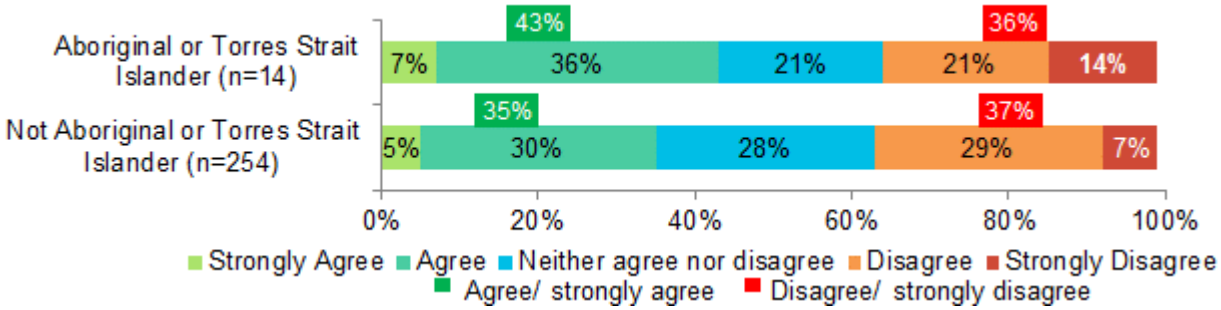
[16] Percentage totals will sometimes appear to not equal the sum of their parts. This is because they are rounded to the nearest integer,
[17] This was significantly different than the percentage for individuals overall.

Figure 31: Individuals' level of agreement that the Commission effectively *reviewed and evaluated mental health and other services, programs and issues*, overall and by individual background (n=274)



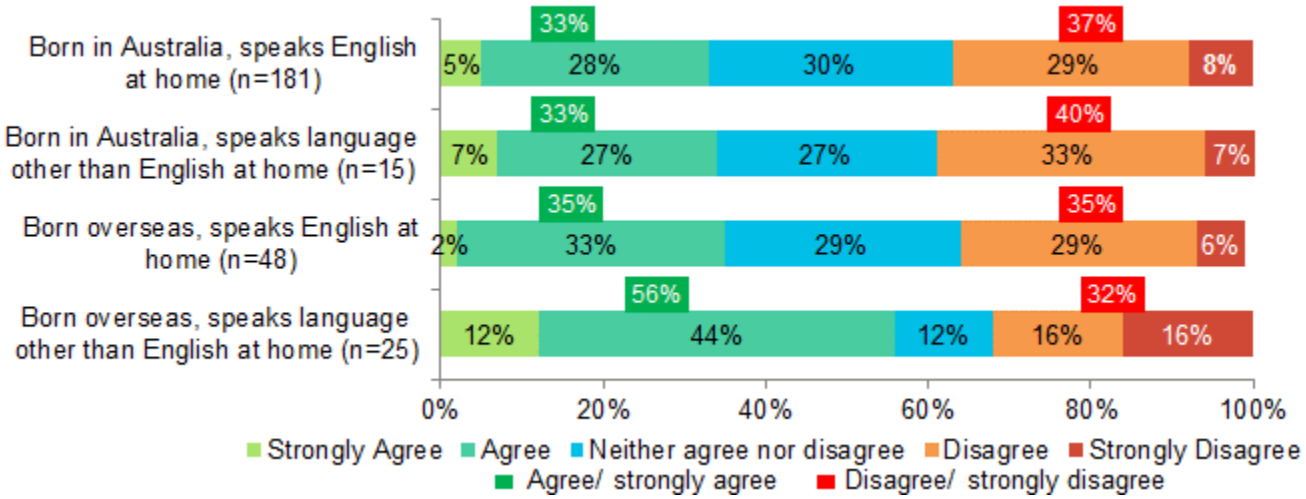

Aboriginal respondents were more inclined than non-Aboriginal respondents to agree/ strongly agree with the effectiveness of the Commission's *reviewing and evaluating* (43% of Aboriginal respondents, 35% of non-Aboriginal respondents).

Figure 32: Level of agreement that the Commission effectively *reviewed and evaluated mental health and other services, programs and issues*, by Aboriginal and Torres Strait Islander origin (n=268)



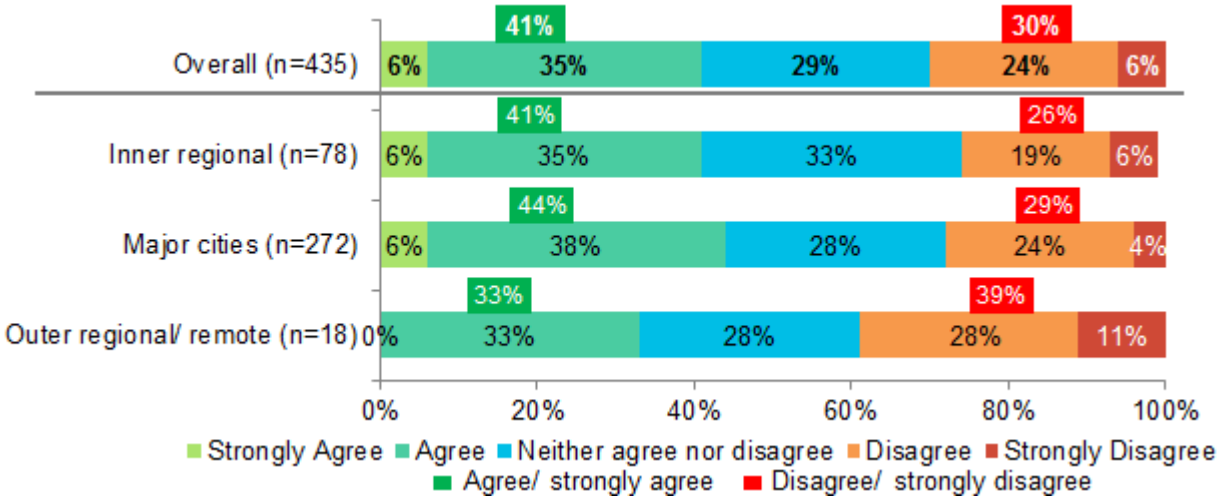

There was little variation between CALD groups, certainly none that was significant. But respondents born overseas, who spoke a language other than English at home, had a higher agree/ strongly agree percentage for the Commission having effectively reviewed and evaluated mental health and other services, programs and issues (56%, compared with 33%-35% for the other CALD groups). These findings can be seen in Figure 33.

Figure 33: Level of agreement that the Commission effectively *reviewed and evaluated mental health and other services, programs and issues*, by culturally and linguistically diverse categories (n=269)




There were no significant differences between the agreement levels of the three remoteness category segments; but the highest proportion of agree/ strongly agree ratings for the Commission's *reviewing and evaluating* work came from major city-based respondents (44%), as shown in Figure 34.

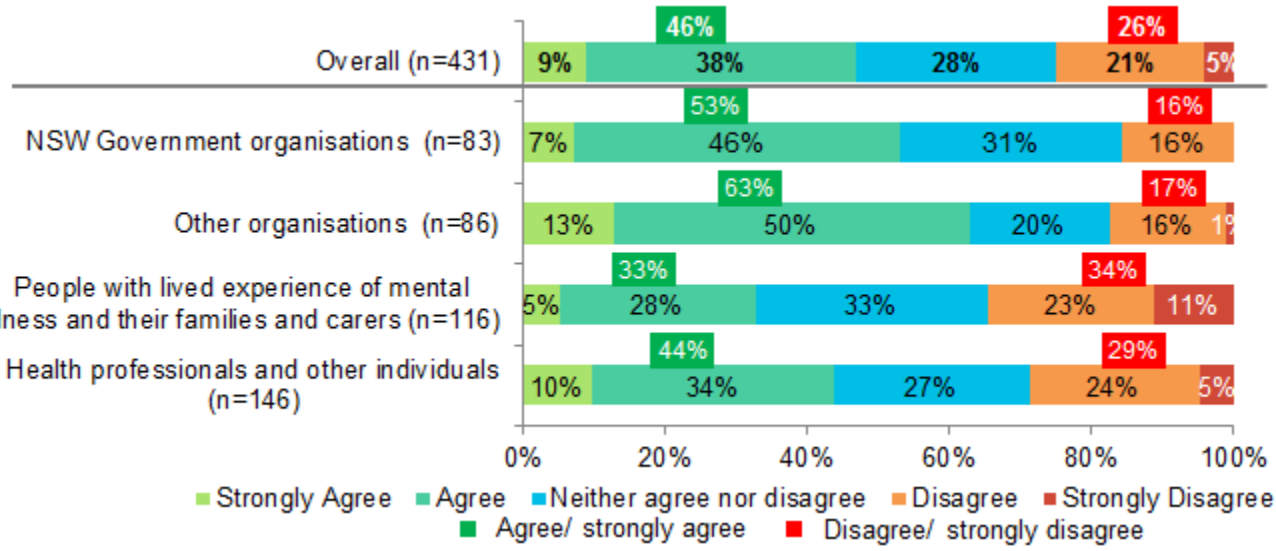
Figure 34: Level of agreement that the Commission effectively *reviewed and evaluated mental health and other services, programs and issues*, overall and by remoteness category (n=435)



### 5.2.2 Reporting and advising on mental health services and programs

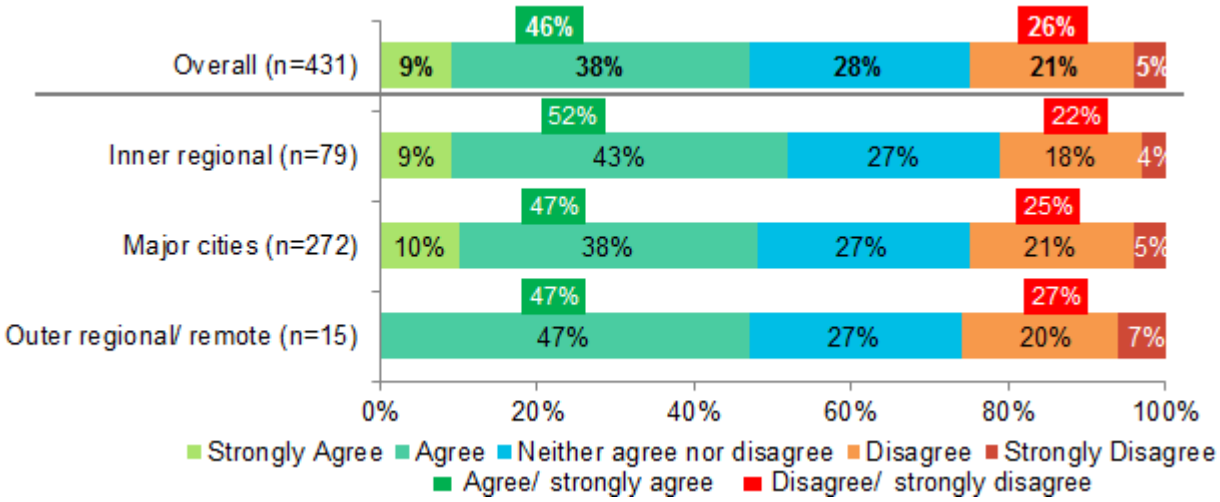
Just under a half (46%) of submissions agreed/ strongly agreed that the Commission had effectively reported and advised on its review and evaluation work discussed in the previous section. The submissions from NSW Government and other organisations were less aligned than they were for most measures; with NSW Government being less positive on this occasion (53% compared with 63% of other organisations). Again, health professionals/other individuals tended to be less positive (44%) and people with lived experience and their families/carers less positive still (33%).

Figure 35: Level of agreement that the Commission effectively *reported and advised on mental health and other services, programs and issues*, overall and by high level organisation and individual groupings (n=431)




There were no significant differences between the agreement levels of the three remoteness category segments; but the highest proportion of agree/ strongly agree ratings for the Commission's *reporting and advising* work came from inner regional respondents (52%), as shown in Figure 36.

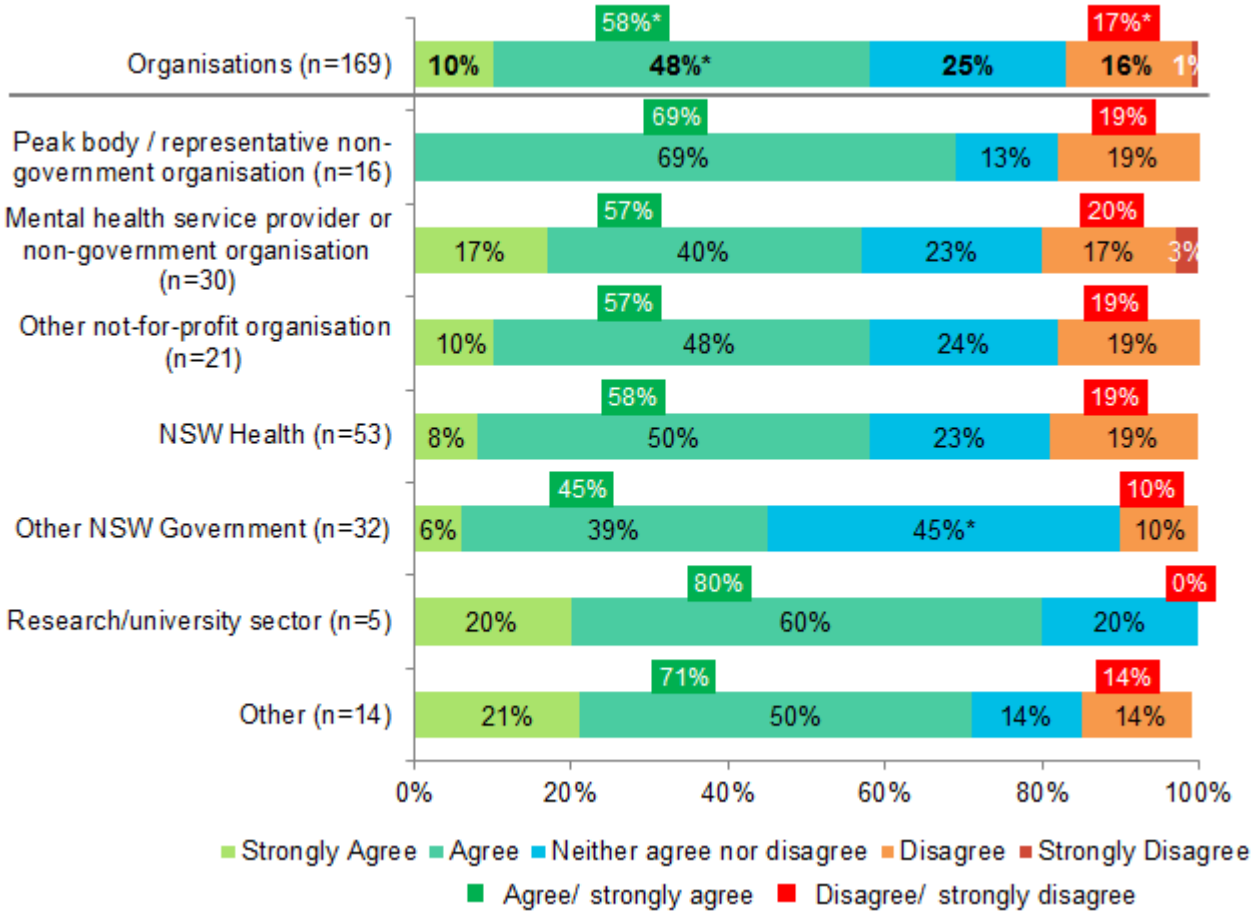
Figure 36: Level of agreement that the Commission effectively *reported and advised on mental health and other services, programs and issues*, overall and by remoteness category (n=431)




Organisations were significantly more positive than individuals about the effectiveness of the Commission in this area, as shown in Figure 37. Fifty-eight percent agreed/ strongly agreed that the *reporting and advising* work had been effective (58%).

There were no statistically significant differences between the agreement levels of each organisation type, except that other NSW Government organisations had a higher rate of respondents who neither agreed nor disagreed that the Commission's *reporting and advising* work had been effective (45%).

Figure 37: Organisations' level of agreement that the Commission effectively *reported and advised on mental health and other services, programs and issues*, overall and by organisation type (n=169)




People with lived experience of mental illness were most likely to strongly disagree that the Commission had effectively reported and advised on services, programs and issues (13%), but family members or carers had the lowest (but not significantly different) agree/ strongly agree rates (30%). (See Figure 38.)

There were no significant differences between Aboriginal/ non-Aboriginal or CALD segments. (See Figure 39 and Figure 40.)

Figure 38: Individuals' level of agreement that the Commission effectively *reported and advised on mental health and other services, programs and issues*, overall and by individual background (n=262)

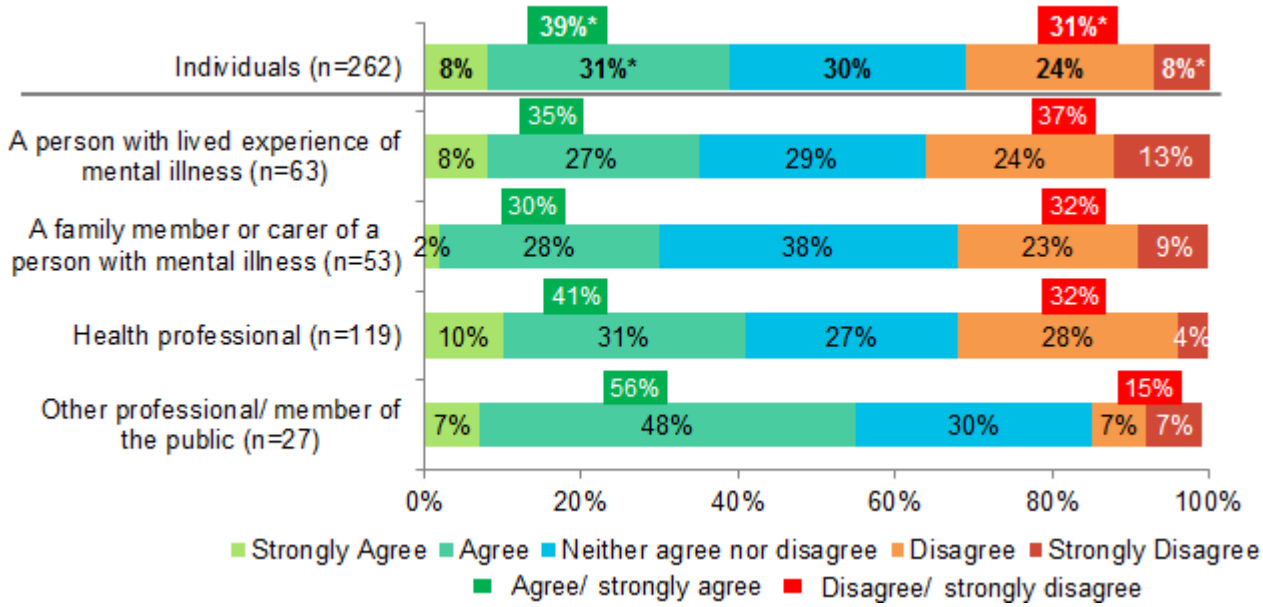



Figure 39: Level of agreement that the Commission effectively *reported and advised on mental health and other services, programs and issues*, by Aboriginal and Torres Strait Islander origin (n=256)

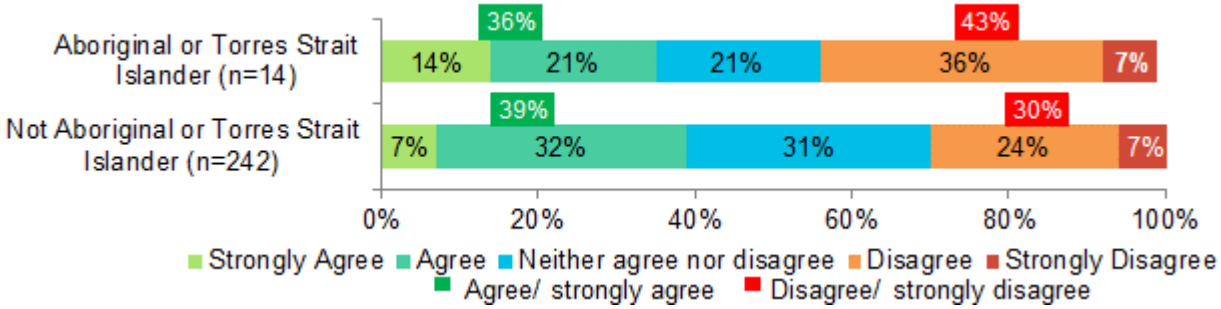
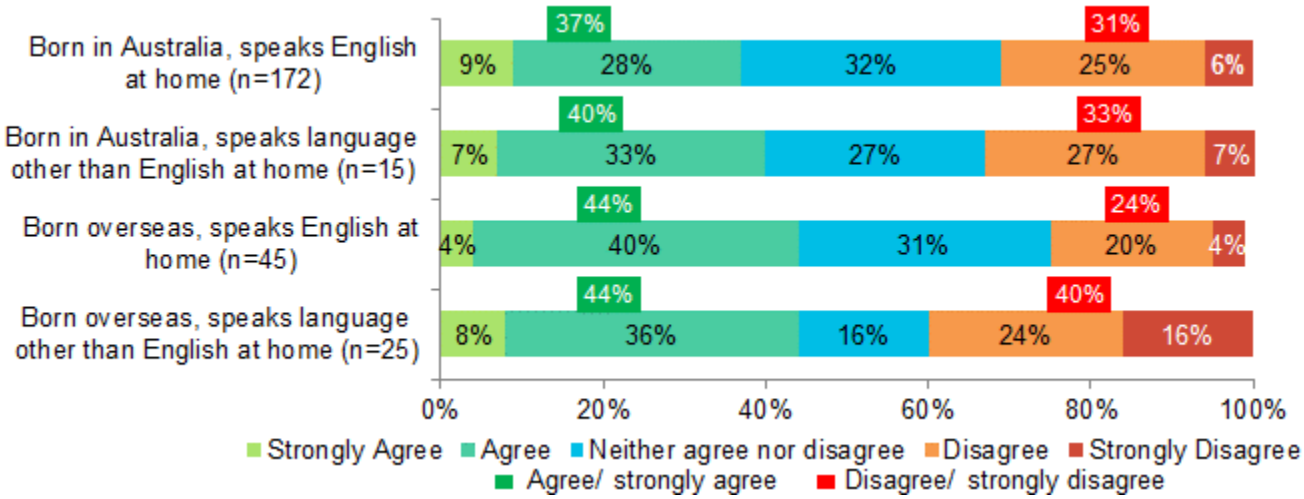


Figure 40: Level of agreement that the Commission effectively *reported and advised on mental health and other services, programs and issues*, by culturally and linguistically diverse categories (n=269)




## 5.2.3 Significant achievements

Respondents who had indicated that they agreed, or strongly agreed, to either of the previous statements about the effectiveness of the Commission's work in reviewing and evaluating, or reporting and advising on mental health and other services, programs and issues, were asked to say, in their own words, what the Commission's most significant achievements had been in this regard. Table 10 lists the three most frequently mentioned topics given in responses to this question overall, and the three topics most frequently mentioned by each of the high level organisation and individual segments.[11]

As with the perceived impact of the strategic plan, when answering this question, respondents thought that heightened public and community awareness about mental health issues was the most positive outcome of the Commission's work, with about a fifth of respondents mentioning this (19%). Many also mentioned greater engagement with people with a lived experience of mental illness (17%), and increased consultation and engagement with carers, health care professionals and services and others, from all across the mental health sector (14%).

The Commission's most important achievement from the perspective of NSW Government (21%), and other organisations (26%), was raising public awareness; whereas the top priority according to people with lived experience of mental illness and their carers (22%), as well as other individuals (15%) was the Commission's engagement with consumers. The segment of individuals which included health professionals also highlighted the Commission's achievements in promoting and supporting the workforce in their top three.

Table 10: Top three significant achievements, overall and by high level organisation and individual groupings

| Topics | n= | Overall | NSW Government organisations | Other organisations | People with lived experience of mental illness and their families and carers | Health professionals and other individuals |
|---|---|---|---|---|---|---|
| | | 133 | 33 | 31 | 23 | 46 |
| Raising public awareness | | 19% | 21% | 26% | 17% | 13% |
| Engaging with consumers/ lived experience | | 17% | 12% | 23% | 22% | 15% |
| Consultation/ engagement | | 14% | 15% | 23% | 4% | 11% |
| Long term platform/ strategy/ framework | | 10% | 15% | 13% | 9% | 4% |
| Needs identification | | 8% | 6% | 16% | 13% | 2% |
| Promotion/ support of peer workforce | | 7% | 3% | - | 9% | 13% |

As listed in Table 11, the same overall themes were broadly echoed by the various organisation types, with common mentions of the Commission's achievements in raising public awareness, and consulting and engaging with the mental health sector, especially people with a lived experience of mental illness themselves. Three 'other' not-for-profit

organisations (50%), and two peak bodies/ representative non-government organisations also mentioned that the Commission had been good at "identifying" or "highlighting" issues, such as "the risks and service gaps for people with mental health challenges."

Table 11: Top three significant achievements mentioned by organisations, overall and by organisation types

| Topics | n= | Organisations overall | Peak body / representative non-government orgs | Mental health service provider or non-gov org | NSW Health | Other NSW Government | Research/university sector | Other not-for-profit org | Other |
|---|---|---|---|---|---|---|---|---|---|
| | | 64 | 6 | 11 | 21 | 12 | 2 | 6 | 6 |
| Raising public awareness | | 23% | 17% | 18% | 19% | 25% | - | 17% | 67% |
| Consultation/ engagement | | 19% | - | 27% | 10% | 25% | 50% | 33% | 17% |
| Engaging with consumers/ lived experience | | 17% | 33% | 27% | 14% | 8% | 50% | - | 17% |
| Needs identification | | 11% | 33% | - | 5% | 8% | - | 50% | - |
| Long term platform/ strategy/ framework | | 14% | - | 9% | 19% | 8% | 50% | - | 33% |
| Review/ provision of support programs | | 6% | - | - | - | 25% | - | - | 17% |
| Focus on early intervention | | 8% | 17% | 9% | 5% | - | - | 33% | - |
| Living Well | | 6% | 33% | 9% | 5% | - | - | - | - |

Some examples of verbatim comments provided by respondents include:

> *"Raising the profile of mental health in the community and addressing seclusion issues."* [Other NSW Government]
>
> *"The provision of support programs and research … the promotion of community awareness of mental health issues."* [Other]
>
> *"Comprehensive consultation process with a specific focus on consumer empowerment and participation."* [Other NSW Government]
>
> *"The level of consumer, carer, and service consultations."* [Other not-for-profit organisation]

*"Carers NSW believes that the Mental Health Commission has succeeded in developing a strong evidence base on key issues that reflects input from consumers, carers and MH professionals."* [Peak body / representative non-government organisation]

*"Person-centred care."* [Mental health service provider or non-government organisation]

*"The clear statement and acknowledgement of the need for early intervention services and how a lack of funding and support services in this area will lead to extensive costs to the community and a poorer prognosis for the client which includes unemployment, homelessness and criminalisation."* [Other not-for-profit organisation]

*"Highlighting what needs fixing."* [Peak body / representative non-government organisation]

*"To say the Commission has 'reviewed and evaluated' services in a specific detailed way is possibly a stretch - it has done a lot more high-level reports and literature reviews and so on … many of these have been very instructive and informative. Apart from the Living Well Report and Plan themselves, I would say the Review into the Transparency and Accountability of Mental Health Funding has been the most solid recent contribution, but the early report of letters received from the different government departments about what they were doing about mental health was also very illuminating and helpful."* [Peak body / representative non-government organisation]

While many of the same topics were raised by individuals as had been by organisations, a significantly higher proportion of individuals spoke highly of the Commission's work in raising the profile of peer workers (12%). Family members and carers, and 'other' professionals/ members of the public also quite often thought that the Commission had been "great at identifying what is needed" (20% and 10% respectively). The top three significant achievements mentioned by individuals from different backgrounds are listed in Table 12.

Table 12: Top three significant achievements mentioned by individuals, overall and by individual background

| Topics | n= | Individuals overall | A person with lived experience of mental illness | A family member or carer of a person with mental illness | Health professional | Other professional/ member of the public |
|---|---|---|---|---|---|---|
| | | 69 | 8 | 15 | 36 | 10 |
| Engaging with consumers/ lived experience | | 17% | 25% | 20% | 17% | 10% |
| Raising public awareness | | 14% | - | 27% | 17% | - |
| Promotion/ support of peer workforce | | 12%* | 25% | - | 14% | 10% |
| Consultation/ engagement | | 9% | 13% | - | 8% | 20% |
| Independent/ external reporting/ accountability | | 7% | - | 7% | 8% | 10% |
| Needs identification | | 6% | - | 20% | 0%* | 10% |
| Thoroughness/ clarity of reporting | | 3% | 13% | - | - | 10% |
| Long term platform/ strategy/ framework | | 6% | 13% | 7% | 3% | 10% |
| Whole of Government/ collaborative approach | | 6% | 13% | 7% | 6% | - |
| Review/ focus on indigenous programs/ services | | 3% | - | - | 3% | 10% |
| Review/ focus on justice system | | 4% | 13% | - | 3% | 10% |
| Recovery focus | | 3% | 13% | - | 3% | - |
| Review/ provision of support programs | | 6% | - | - | 8% | 10% |
| Living Well | | 4% | 13% | 7% | 3% | - |

Some examples of verbatim comments provided by respondents include:

*"Inclusiveness of people with a mental health diagnosis in policy making."* [A person with lived experience of mental illness]

*"Promoting the importance of understanding lived experience."* [Health professional]

*"Gaining media attention to spread information and increase awareness."* [A family member or carer of a person with mental illness]

"*Bringing to attention the importance of acknowledging peer workers/lived experience.*" [A person with lived experience of mental illness]

*"Its ability to consult and work with stakeholders, as well to develop appropriate services for people with mental health and their family members."* [Other professional]

*"Increased transparency."* [Health professional]

"*I have noticed that they are attempting to hold services accountable for what they are or are not doing."* [Health professional]

*"Evaluating and commenting on best practices."* [A family member or carer of a person with mental illness]

*"The production of their report."* [Other professional]

*"Better implementation of mental health plan, improved access to psychologists and enhanced patient education."* [Health professional]

*"It is a whole of government plan."* [A person with lived experience of mental illness]

One Aboriginal respondent mentioned an achievement in recognising the interactions between past mental health policies and issues relevant to the mental health of Aboriginal peoples (33%), and one thought the Commission's review of the justice system had been "extremely significant" (33%).

Table 13: Top three significant achievements, by Aboriginal and Torres Strait Islander origin

| Topics n= | Aboriginal 3 | Not Aboriginal 65 |
|---|---|---|
| Raising public awareness | 33% | 12% |
| Engaging with consumers/ lived experience | - | 18% |
| Independent/ external reporting/ accountability | - | 8% |
| Consultation/ engagement | - | 9% |
| Promotion/ support of peer workforce | - | 12% |
| Review/ focus on indigenous programs/ services | 33% | 2% |
| Review/ focus on justice system | 33% | 3% |

Some examples of verbatim comments provided by respondents include:

ABORIGINAL AND TORRES STRAIT ISLANDERS:

*"Recognition of the historical impact on Aboriginal people of past policies, including those specific to mental health."* [Health professional]

> *"The review into the justice system was extremely significant; this issue is often overlooked by the public and other reporting."* [A person with lived experience of mental illness]

While the Commission's significant achievement in engaging with people with a lived experience of mental illness was important to all CALD groups, it's work in raising public awareness of mental health issues tended to be considered more important by respondents born overseas (38% of those who spoke a language other than English at home, 18% of those who spoke English at home), than those born in Australia (8% of those who spoke English at home, none (0%) of the four who spoke another language at home).

Table 14: Top three significant achievements, by culturally and linguistically diverse categories

| Topics | n= | Born in Australia, speaks English at home<br>38 | Born in Australia, speaks language other than English at home<br>4 | Born overseas, speaks English at home<br>17 | Born overseas, speaks language other than English at home<br>8 |
|---|---|---|---|---|---|
| Engaging with consumers/ lived experience | | 13% | 25% | 24% | 25% |
| Promotion/ support of peer workforce | | 13% | - | 12% | 13% |
| Consultation/ engagement | | 11% | - | 6% | 13% |
| Independent/ external reporting/ accountability | | 8% | 25% | 6% | - |
| Needs identification | | 0%* | - | 24% | - |
| Thoroughness/ clarity of reporting | | 3% | 25% | - | - |
| Long term platform/ strategy/ framework | | 3% | - | 6% | 13% |

| Topics | n= | Born in Australia, speaks English at home | Born in Australia, speaks language other than English at home | Born overseas, speaks English at home | Born overseas, speaks language other than English at home |
|---|---|---|---|---|---|
| | | 38 | 4 | 17 | 8 |
| Raising public awareness | | 8% | - | 18% | 38% |
| Whole of Government/ collaborative approach | | 5% | 25% | - | 13% |
| Focus on early intervention | | 5% | 25% | 6% | - |
| Living Well | | 5% | - | - | 13% |

Some examples of verbatim comments provided by respondents include:

BORN IN AUSTRALIA, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

*"Championing consumer and carer involvement in services."* [Health professional]

*"Outcomes need to start getting measured and reported on more at a program and LHD level."* [Health professional]

*"The production of their report."* [Other professional]

*"Being able to bring to light the work of so many other organisations."* [Health professional]

BORN OVERSEAS, SPEAKS ENGLISH AT HOME:

*"The policy of the inclusion of consumers and carers in deciding treatment."* [A family member or carer of a person with mental illness]

*"Great at identifying what is needed. I would like to see more action on recommendations, but that is dependent on funding."* [A family member or carer of a person with mental illness]

*"A modest amount of publicity."* [A family member or carer of a person with mental illness]

BORN OVERSEAS, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

> *"Highlighting that mental health [issues are] rising in our society."* [Health professional]
>
> *"Mapping out mental health services and building community resilience and wellbeing."* [Other professional]
>
> *"The raising of awareness about the importance of peer work."* [A person with lived experience of mental illness]
>
> *"Its ability to consult and working with stakeholders as well to develop appropriate services for people with mental health and their family members."* [Other professional]
>
> *"To collaborate with non-government services and clinical treatment teams."* [A family member or carer of a person with mental illness]
>
> *"Living Well."* [A family member or carer of a person with mental illness]

Five respondents from regions other than major cities also thought that the Commission had provided a useful framework and direction for mental health services and programs to collectively operate under (16% of inner, outer regional or remote respondents).

Table 15: Top three significant achievements, overall and by remoteness category

| Topics | n= | Overall 133 | Major cities 85 | Inner regional 26 | Outer regional / remote 5 |
|---|---|---|---|---|---|
| Raising public awareness | | 19% | 20% | 19% | - |
| Engaging with consumers/ lived experience | | 17% | 18% | 12% | 60% |
| Consultation/ engagement | | 14% | 18% | 4% | - |
| Needs identification | | 8% | 6% | 19% | - |
| Long term platform/ strategy/ framework | | 10% | 9% | 15% | 20% |
| Review/ provision of support programs | | 6% | 8% | - | 20% |
| Focus on early intervention | | 7% | 5% | 12% | 20% |

Some examples of verbatim comments provided by respondents include:

MAJOR CITIES:

*"Maintaining the focus on mental health is important, as outside those specifically involved, most people do not want to discuss mental health issues … it is a taboo subject."* [Other not-for-profit organisation]

*"Enhancing the consumer advocate role and increasing awareness of the needs of those with mental health illness."* [NSW Health]

*"It has strengthened the consumer voice and highlighted certain areas of service delivery, such as Open Dialogue and Suicide Prevention."* [Health professional]

*"Identification of neglected populations and areas … setting a vision/plan to do things differently for those populations and areas. Achievements have been hampered by the lack of access to key data that would enable reporting of impact/progress."* [Research/university sector]

INNER REGIONAL:

*"Raising awareness of mental health issues."* [A family member or carer of a person with mental illness]

*"Raising the profile and importance of an effective mental health system for NSW."* [Other NSW Government, Inner Regional]

*"Issues were identified which is good however a lot more strategies need to be put in place to help individuals and their families. Services are virtually non-existent in rural areas."* [Member of the public (none of the above)]

*"Working closely with the Department of Education to promote positive strategies. including the MWIA."* [Other NSW Government]

*"Put forward some great policies and planning in support of people experiencing a mental illness."* [A person with lived experience of mental illness]

OUTER REGIONAL/REMOTE:

*"The policy of the inclusion of consumers and carers in deciding treatment."* [A family member or carer of a person with mental illness]

*"Guidance and reference."* [NSW Health]

*"An increase in mental health support services and recurrent funding for said services."* [Other NSW Government]

### 5.2.4 Suggestions for more effectively focusing the Mental Health Commission's work

Respondents who had indicated that they were neutral, or disagreed or strongly disagreed, to either of the statements about the effectiveness of the Commission's work in reviewing and evaluating, or reporting and advising on mental health and other services, programs and issues, were asked to describe, in their own words, how the Commission could more effectively focus this work.

Many respondents (24%) were concerned with the lack of availability of services, or with the difficulty in timely access to services for individuals who needed them. They often cited resourcing issues as the cause of this.

The second most common suggestion for the Commission to consider was an enhanced focus on consumer (23%), and professional stakeholder (16%) engagement and consultation. Consumer engagement was the top priority of individuals with lived experience and their carers (35%), followed closely by service accessibility (33%). The third priority for this segment was increased consumer rights (15%).

The top suggestion from submissions within NSW Government organisations was that the Commission should focus on standardised objectives and outcome frameworks in order to enhance its accountability (32%).

Table 16: Top three suggestions for how the MHC could more effectively focus its work, overall and by high level organisation and individual groupings

| Topics | n= | Overall<br>176 | NSW Government organisations<br>28 | Other organisations<br>25 | People with lived experience of mental illness and their families and carers<br>55 | Health professionals and other individuals<br>68 |
|---|---|---|---|---|---|---|
| Improved access to services | | 24% | 21% | 16% | 33% | 21% |
| Consumer/ user engagement/ consultation | | 23% | 14% | 12% | 35% | 22% |
| Stakeholder consultation/ engagement | | 16% | 18% | 28% | 5% | 19% |
| Standardised objectives & outcome frameworks/ accountability | | 15% | 32% | 28% | 5% | 10% |

| Topics | n= | Overall 176 | NSW Government organisations 28 | Other organisations 25 | People with lived experience of mental illness and their families and carers 55 | Health professionals and other individuals 68 |
|---|---|---|---|---|---|---|
| Increased consumer rights/ accountability focus | | 6% | - | 4% | 15% | 1% |

Organisations particularly wanted to see the Commission monitoring government agencies or its own performance against more clearly defined outcome measures (30% of organisations). NSW Health respondents and mental health service providers were most keen on this (47% and 40% respectively). All organisations also frequently mentioned that they would like to see increases in stakeholder consultation and broader sector engagement, with the Commission drawing a range of government agencies into discussions (23% of organisations).

Table 17: Top three suggestions for how the MHC could more effectively focus its work mentioned by organisations, overall and by organisation types

| Topics | r | Organisations overall 53 | Peak body / representative non-government orgs 5 | Mental health service provider or non-gov org 10 | NSW Health 17 | Other NSW Government 11 | Research/university sector 1 | Other not-for-profit org 5 | Other 4 |
|---|---|---|---|---|---|---|---|---|---|
| Standardised objectives & outcome frameworks/ accountability | | 30%* | 20% | 40% | 47% | 9% | - | 20% | 25% |
| Stakeholder consultation/ engagement | | 23% | 40% | 20% | 18% | 18% | - | 20% | 50% |
| Improved access to services | | 19% | - | 10% | 18% | 27% | - | 20% | 50% |

| Topics | r | Organisations overall 53 | Peak body / representative non-government orgs 5 | Mental health service provider or non-gov org 10 | NSW Health 17 | Other NSW Government 11 | Research/university sector 1 | Other not-for-profit org 5 | Other 4 |
|---|---|---|---|---|---|---|---|---|---|
| Communication clarity/ transparency | | 8% | - | - | 12% | 9% | 100% | - | - |
| Consumer/ user engagement/ consultation | | 13%* | 20% | 10% | 12% | 18% | - | - | 25% |
| Increased authority/ scope/ accountability | | 8% | 20% | - | 6% | 9% | - | 20% | - |
| Increased consumer rights/ accountability focus | | 2% | - | 10% | - | - | - | - | - |
| Information dissemination | | 6% | - | 10% | - | 18% | - | - | - |
| More/ more equitable funding | | 11% | 20% | - | 6% | 27% | - | 20% | - |

Some examples of verbatim comments provided by respondents include:

> *"More work on a standardised outcomes framework for assessing client outcomes with regard to their participation in programs/activities."* [Mental health service provider or non-government organisation]
>
> *"The work of the Commission, given its funding, could be more focussed and the next iteration of planning could identify a smaller number of high priority initiatives to address reorienting health services. An explicit health promotion framework could be useful to guide the work of the Commission and hopefully eventually lead to the kinds of population outcomes that other areas (like tobacco control and HIV) have achieved by adopting a strong health promotion framework."* [Other not-for-profit organisation]
>
> *"Consider how to engage with organisations, or connect them to the relevant areas, for greater mental health impact." [Other not-for-profit organisation]*

*"Funding remains an issue … mental health is a huge issue for children, young people and their families. As well as medical/psychological interventions, practical supports would greatly assist i.e. transport, access to after-school services and holiday programs across the state, more support options for children and young people if their family carers have a mental illness."* [Other NSW Government]

*"There is an urgent need for mental health facilities. I know of one family with a severely violent schizophrenic son, who ended up committing suicide … every time [the mother] sought help for her son, they would release him into society. The government closed a lot of institutions and there is a major need to have better facilities opened again."* [Other]

*"Write clearly and set out clear objectives, rather than writing in vague terms and promoting yet more bureaucracy."* [NSW Health]

*"Rather than highlighting the information it would like but can't get from service providers, the Commission needs to be clearer about what it will report on and how. Reporting needs to be more regular, more easily accessible (a dashboard/quick overview rather than couched in a single, lengthy report) and it needs to quantify how (and how much) things have shifted/changed/improved."* [NSW Health]

While stakeholder consultation was an important agenda item for organisations, increased consumer engagement was most frequently mentioned by individuals (28%), especially people with a lived experience of mental illness (41%) and 'other' professionals/ members of the public (38%). As listed in Table 18, individuals, particularly those with a mental illness and their families or carers, also wanted the Commission to focus on improving access to mental health services (26% of individuals overall, 31% of people with a lived experience, 35% of their family members or carers). Health professionals wanted to see an increase in the Commission's stakeholder consultation activities (20%).

Table 18: Top three suggestions for how the MHC could more effectively focus its work mentioned by individuals, overall and by individual background

| Topics | n= | Individuals overall | A person with lived experience of mental illness | A family member or carer of a person with mental illness | Health professional | Other professional/ member of the public |
|---|---|---|---|---|---|---|
| | | 123 | 29 | 26 | 60 | 8 |
| Consumer/ user engagement/ consultation | | 28%* | 41% | 27% | 20% | 38% |
| Improved access to services | | 26% | 31% | 35% | 23% | - |
| Stakeholder consultation/ engagement | | 13% | - | 12% | 20%* | 13% |
| Communication clarity/ transparency | | 5% | - | 8% | 3% | 25% |
| Increased authority/ scope/ accountability | | 12% | 3% | 12% | 17% | 13% |
| Increased consumer rights/ accountability focus | | 7% | 17% | 12% | 2%* | - |
| More/ more equitable funding | | 5% | - | 4% | 7% | 13% |

Some examples of verbatim comments provided by respondents include:

> *"No-one has asked me to evaluate anything, yet I have been using the NSW mental health services for over 29 years. Not for myself, but for family members."* [A family member or carer of a person with mental illness]
>
> *"More lived experience involvement."* [A person with lived experience of mental illness]
>
> *"Increase staff numbers to deal with incoming calls from participants."* [A person with lived experience of mental illness]
>
> *"Sometimes there are not enough resources for people who are suffering and are turned away or misdiagnosed or just given a pill which does not work."* [A family member or carer of a person with mental illness]
>
> *"There needs to be stronger engagement with primary health care, public hospitals - especially regional hospitals, with drug and alcohol services, and a focus on community and public health systems."* [Health professional]

*"It would be great if the role of the Mental Health Commission was publicised more, so that everybody knew how they could contribute to improve the system and also assist those who are unable to voice their concerns, thoughts and opinions."* [A person with lived experience of mental illness]

*"Hands on approach. Listen and speak to families, carers and patients. Act on complaints; don't just sweep them under the mat!"* [A family member or carer of a person with mental illness]

Two of eight Aboriginal respondents wanted to see the Commission's scope and authority expanded so that it could "actually drive change" (25%).

Table 19: Top three suggestions for how the MHC could more effectively focus its work, by Aboriginal and Torres Strait Islander origin

| Topics n= | Aboriginal 8 | Not Aboriginal 112 |
|---|---|---|
| Consumer/ user engagement/ consultation | 38% | 27% |
| Increased authority/ scope/ accountability | 25% | 12% |
| Standardised objectives & outcome frameworks/ accountability | - | 9% |
| Improved access to services | 38% | 26% |
| Stakeholder consultation/ engagement | - | 14% |

Some examples of verbatim comments provided by respondents include:

ABORIGINAL AND TORRES STRAIT ISLANDERS:

*"Get out and talk to the community to see what they want, not what the government wants to provide."* [Health professional]

*"[The MHC] needs to engage more with actual mental health sufferers, rather than the multitude of NGOs who do little to help or represent us."* [A person with lived experience of mental illness]

*"It does not have the capacity to make changes in the services or community."* [Health professional]

*"I think that the Commission should have been given the independent review into Seclusion & Restraint by NSW Health. Although I understand this isn't a decision to be made by the Commission, the Commission does have these powers under the*

*Act and should push to have these used by NSW Health."* [A person with lived experience of mental illness]

For the three smaller CALD segments (respondents *not* born in Australia and speaking English at home), consumer engagement was a particularly high priority, and was mentioned by the largest percentages of respondents in those segments (ranging from 29% of those born in Australia, speaking a language other than English at home, to 38% of respondents born overseas, speaking a language other than English at home). Improved access to services was also important to all CALD groups, but significantly more important to Australian born, English speakers (32%, compared to 13% to 25% of other CALD groups). (See Table 20.)

Table 20: Top three suggestions for how the MHC could more effectively focus its work, by culturally and linguistically diverse categories

| Topics | n= | Born in Australia, speaks English at home | Born in Australia, speaks language other than English at home | Born overseas, speaks English at home | Born overseas, speaks language other than English at home |
|---|---|---|---|---|---|
| | | 82 | 7 | 23 | 8 |
| Improved access to services | | 32%* | 14% | 13% | 25% |
| Consumer/ user engagement/ consultation | | 26% | 29% | 30% | 38% |
| Increased authority/ scope/ accountability | | 15% | 14% | 9% | - |
| Standardised objectives & outcome frameworks/ accountability | | 9% | 29% | 4% | - |
| Increased consumer rights/ accountability focus | | 7% | 14% | 4% | 13% |
| Stakeholder consultation/ engagement | | 11% | 14% | 22% | 13% |
| Information dissemination | | 7% | 14% | 9% | 13% |
| More/ more equitable funding | | 2% | - | 9% | 13% |

Some examples of verbatim comments provided by respondents include:

BORN IN AUSTRALIA, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

*"Publicise the fact that the strategy is being reviewed and call for submissions from the public using non-traditional advertising, for example, Facebook, Instagram, etc."* [A person with lived experience of mental illness]

*"Mandated outcome measurement and public performance reporting."* [Health professional]

*"More education and training for health service professionals; more training for FACS staff. More assistance for families who have a person with a mental health issue who refuses to get help or treatment for the mental health problem."* [Member of the public (none of the above)]

*"It would be great if the role of the Mental Health Commission was publicised more."* [A person with lived experience of mental illness]

BORN OVERSEAS, SPEAKS ENGLISH AT HOME:

*"Engaging across the board with providers, carers and patients … recognising that some people fill all three roles at some time or another."* [Health professional]

*"More consultation with consumers and the health professionals who care for them."* [Health professional]

*"More involvement to ensure that people are getting the help they need, when they need it. It is not working now."* [A family member or carer of a person with mental illness]

BORN OVERSEAS, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

*"[The MHC needs to] ensure that consumers have a say in what is happening and how service are delivered. Relying on an organisation's view is old fashioned and shuts down the voice of consumers. The Mental Health Commission needs to have a seat inside every organisation and get information from reception to CEO level."* [A person with lived experience of mental illness]

*"Have support staff/interpreters, as well as more compassion/ understanding … these people are facing a lot of challenges."* [A family member or carer of a person with mental illness]

*"The focus should also be on CALD populations, as they have low mental health literacy and poor help-seeking behaviour. Therefore, there should be more consultation with CALD community groups, including refugee populations."* [A person with lived experience of mental illness]

*"More mental health education and promotion."* [Health professional]

*"Put more money and support at the grass roots [level]."* [Health professional]

A quarter of those who thought that the Commission's reviewing, evaluating, reporting and advising work had not been effective, wanted it to focus on improving access to mental health services and programs (24%). A focus on improving accessibility to mental health services was increasingly important to respondents the further they were from major cities; the significantly lowest percentage of respondents mentioning this topic were from major cities (19%), while a third of inner regional respondents did (32%), and seven of the ten outer regional/ remote respondents did (70%).

Table 21: Top three suggestions for how the MHC could more effectively focus its work, overall and by remoteness category

| Topics n= | Overall 176 | Major cities 108 | Inner regional 31 | Outer regional / remote 10 |
|---|---|---|---|---|
| Improved access to services | 24% | 19%* | 32% | 70% |
| Consumer/ user engagement/ consultation | 23% | 21% | 23% | 20% |
| Stakeholder consultation/ engagement | 16% | 19% | 10% | 10% |
| Standardised objectives & outcome frameworks/ accountability | 15% | 19% | 10% | - |
| Increased authority/ scope/ accountability | 11% | 11% | 13% | - |

Some examples of verbatim comments provided by respondents include:

MAJOR CITIES:

*"More consultation with consumers and the health professionals who care for them."* [Health professional]

*"Keep on engaging the public and those that are experiencing mental health issues."* [Health professional]

*"The MHC has not sufficiently dealt with the intersection between mental illness and homelessness, and the high incidence of mental illness amongst social housing tenants and their need for prioritised services to sustain their tenancies."* [Other NSW Government]

*"Introducing better access to services and reporting on best possible services that would meet individual needs."* [A family member or carer of a person with mental illness]

*"Contact with clinicians on the coal face about what is necessary. Taking a big picture view of mental health services."* [NSW Health]

*"Have a better working relationship or Memorandum of Understanding with the Aboriginal Legal Service in New South Wales."* [Peak body / representative non-government organisation]

*"The Plan lacks clearly identified outcomes or outputs ('deliverables'), time lines, accountabilities, reporting mechanisms and requirements which could allow us to clearly measure its progress. To this extent it is more like a 'vibe' than a detailed, deliverable plan."* [Peak body / representative non-government organisation]

INNER REGIONAL:

*"The demand for services outstrips supply. There needs to be a closer look at resource allocation into smaller rural and remote locations."* [Other not-for-profit organisation]

*"Ensure that rural/remote areas have better mental health facilities to cope with the increasing MH presentations. Not everyone can travel over 100 kilometres to get assistance. Not everyone has access to a computer, mobile phone, etc due to the difficulties with 'black spots'."* [Health professional]

*"It needs to engage more with actual mental health sufferers, rather than the multitude of NGOs who do little to help or represent us."* [A person with lived experience of mental illness]

*"Listen to consumers about their experience."* [Other professional]

*"The Commission itself has no 'teeth'. It is thus duplicating the work of other community-based organisations."* [Health professional]

OUTER REGIONAL/REMOTE:

*"Rural areas need serious attention."* [A person with lived experience of mental illness]

*"Review and evaluate the impact of the lack of services available in rural Australia, in an attempt to get some basic level support initiated in these areas."* [A person with lived experience of mental illness]

*"Be inclusive of all areas, not just the cities."* [Health professional]

*"Speak to consumers and carers, as well as LHD staff."* [Health professional]

*"More of a community response … more reviewing done with on the ground workers. Being rural presents with a number of issues."* [Mental health service provider or non-government organisation]

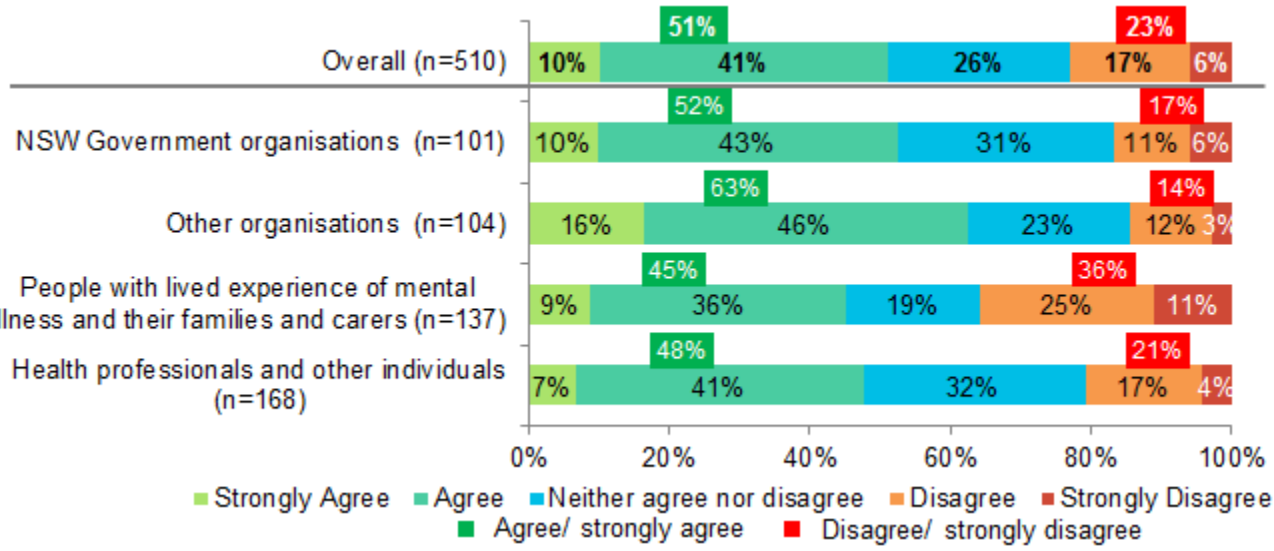
## 5.3 Knowledge sharing

The fourth function outlined by the Act was for the Mental Health Commission to *promote and facilitate the sharing of knowledge and ideas about mental health issues.*

### 5.3.1 The promotion and facilitation of knowledge sharing about mental health issues

Half of respondents (51%) agreed/ strongly agreed that the Commission had promoted and facilitated knowledge sharing about mental health issues in an effective way. Those with lived experience of mental illness/their carers were the least positive (45%), with health professionals/other individuals showing similar levels of agreement (48%). The most positive result (63%) came from 'other' organisations (i.e. not pertaining to NSW Government).

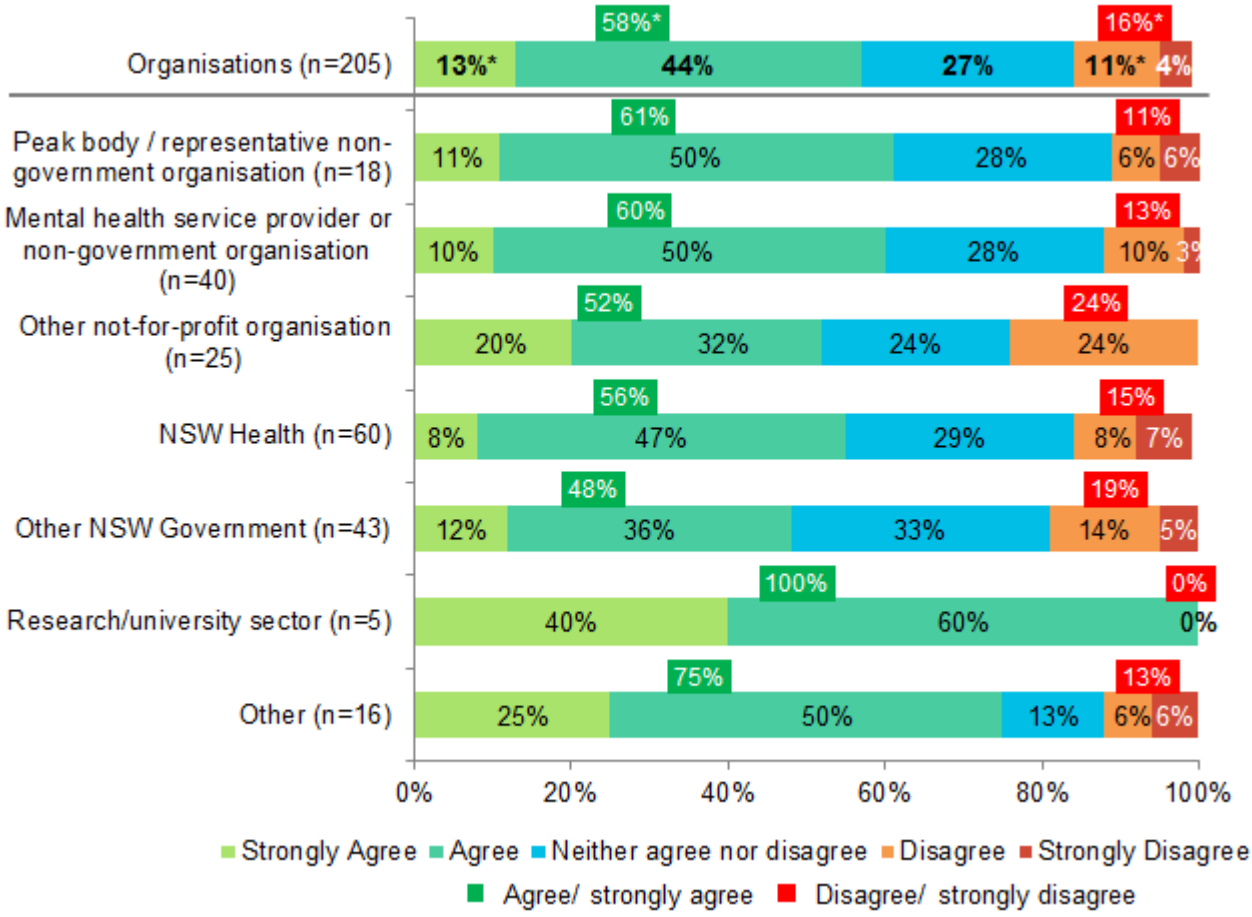
Figure 41: Level of agreement that the Commission *promoted and facilitated knowledge sharing about mental health issues in an effective way*, overall and by high level organisation and individual groupings (n=510)




Apart from the five respondents from the research/ university sector, who all agreed/ strongly agreed that the Commission had effectively promoted and facilitated knowledge sharing (100%), other organisations, peak bodies/ representative non-government organisations, and mental health service providers or non-government organisations were

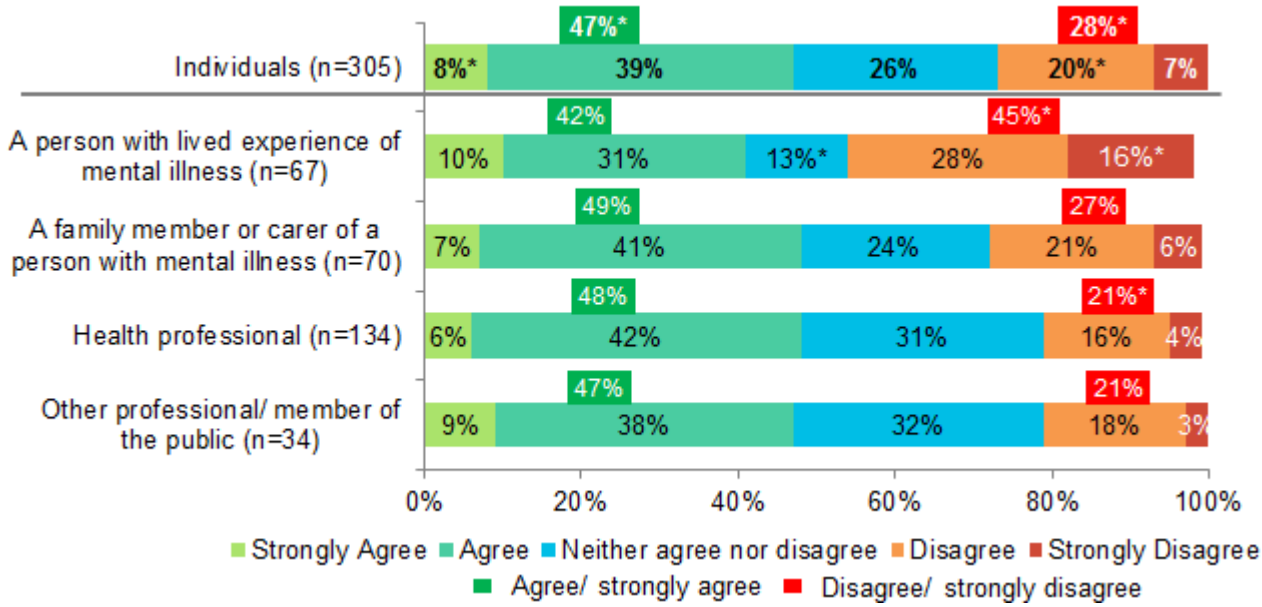
the organisation types with the highest proportions of agreeing/ strongly agreeing respondents (75%, 61% and 60% respectively, but not statistically different from organisations overall). (See Figure 42.)

Figure 42: Organisations' level of agreement that the Commission *promoted and facilitated knowledge sharing about mental health issues in an effective way*, overall and by organisation type (n=205)




Just under half of individuals agreed/ strongly agreed that the Commission had effectively promoted and facilitated knowledge sharing (47%). As shown in Figure 43, respondents with a lived experience of mental illness were significantly more likely than individuals overall to disagree/ strongly disagree (45%, compared to 28% overall), but health professionals were significantly less likely to disagree/ strongly disagree (21%).

Figure 43: Individuals' level of agreement that the Commission *promoted and facilitated knowledge sharing about mental health issues in an effective way*, overall and by individual background (n=305)




There were no significant differences in Aboriginal and non-Aboriginal respondents' agreement ratings, nor between those given by the four CALD groups. Non-Aboriginal respondents and those born overseas, who spoke English at home had slightly higher rates of agree/ strongly agree than their counterparts (47% non-Aboriginal respondents, 44% Aboriginal respondents; 52% born overseas, speaks English at home, 41%-50% other CALD groups).

See Figure 44 for agreement levels by Aboriginal/ non-Aboriginal respondents, and Figure 45 for agreement levels by CALD categories.

Figure 44: Level of agreement that the Commission *promoted and facilitated knowledge sharing about mental health issues in an effective way*, by Aboriginal and Torres Strait Islander origin (n=301)

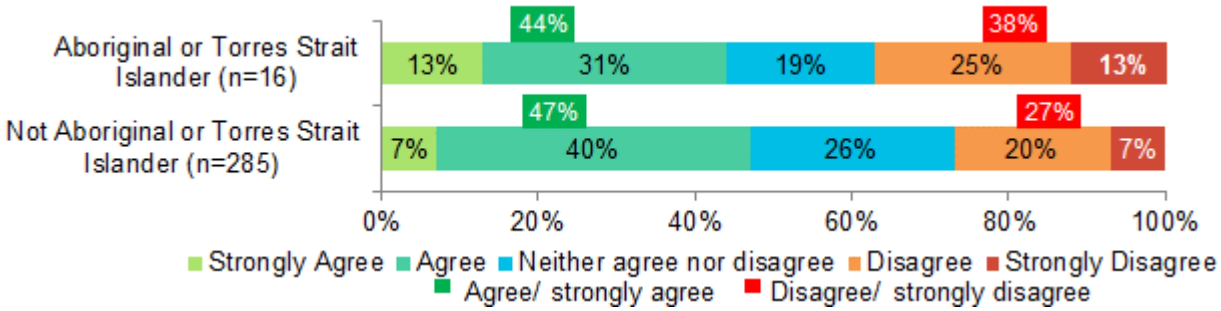
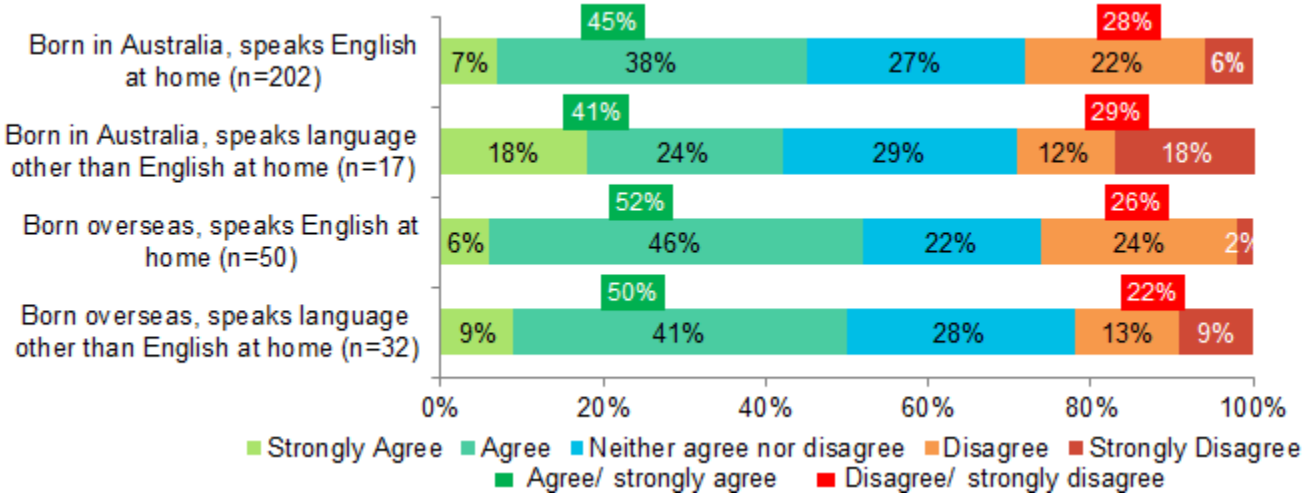
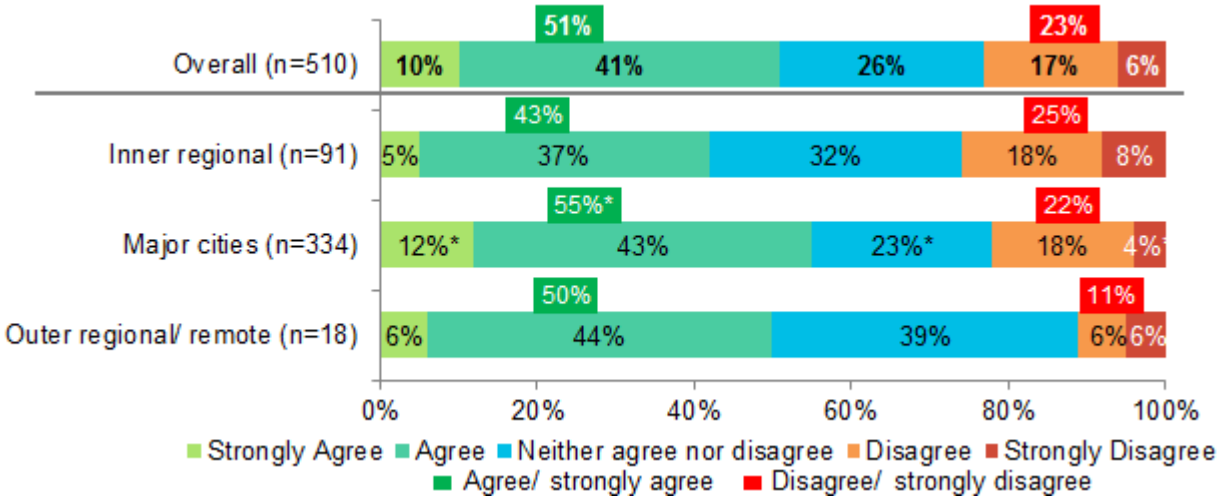


Figure 45: Level of agreement that the Commission *promoted and facilitated knowledge sharing about mental health issues in an effective way*, by culturally and linguistically diverse categories (n=301)




More than half of those in major cities agreed/ strongly agreed with this statement (55%, which was statistically, significantly higher than the overall result).

Figure 46: Level of agreement that the Commission *promoted and facilitated knowledge sharing about mental health issues in an effective way*, overall and by remoteness category (n=510)



### 5.3.2 Suggestions for further promotion and facilitation of the sharing of knowledge

When respondents were neutral, or disagreed or strongly disagreed that the Commission had promoted and facilitated knowledge sharing about mental health issues in an effective way, they were asked to suggest what the Commission could do to further promote and facilitate this knowledge sharing.

Increased consumer engagement, the provision of more educational information (including through conferences, publications, mobile phone apps, social media, or videos, for example), and additional stakeholder consultation were the most common suggestions, overall (all three 21%).

Increased user engagement, in the context of knowledge sharing, was the top suggestion of people with a mental health condition and their carers (33%). This was followed by use of the media (20%) and dissemination via publications and forums (17%).

NSW Government responses also highlighted the media (27%) and publications and forums (27%), and they also put wider collaboration with NGOs and private providers in their top three (15%).

Table 22: Top three suggestions for further promotion and knowledge sharing facilitation, overall and by high level organisation and individual groupings

| Topics | n= | Overall 184 | NSW Government organisations 33 | Other organisations 28 | People with lived experience of mental illness and their families and carers 60 | Health professionals and other individuals 63 |
|---|---|---|---|---|---|---|
| Lived experience/ user engagement/ consultation | | 21% | 3% | 11% | 33% | 24% |
| Information dissemination - promotion/ availability of publications/ networks/ forums, etc. | | 21% | 27% | 21% | 17% | 22% |
| Wider collaboration/ consultation - NGOs, private providers, etc. | | 21% | 15% | 29% | 13% | 29% |

| Topics | n= | Overall 184 | NSW Government organisations 33 | Other organisations 28 | People with lived experience of mental illness and their families and carers 60 | Health professionals and other individuals 63 |
|---|---|---|---|---|---|---|
| Media/ general population awareness & advertising | | 19% | 27% | 11% | 20% | 17% |
| Improved access to services - regional/ rural areas, etc. | | 9% | 6% | 14% | 7% | 10% |
| More resources/ support | | 11% | 6% | 14% | 8% | 14% |

While the desire for information dissemination, stakeholder collaboration and consultation, and increased publicity of mental health issues within the wider community were common themes for most organisation types (25%, 21% and 20% of organisations overall), the desire to have additional resourcing for support services, rather than just increased knowledge provision, was expressed particularly by 'other' not-for-profit organisations (33%), peak bodies and representative non-government organisations (20%), and representatives from areas of NSW Government, other than NSW Health (13%), as shown in Table 23. These 'other' NSW Government and 'other' not-for-profit organisations were also interested in seeing more collaboration between the Commission and the Education Department and an increase in the promotion of knowledge about mental health issues by teaching students about the issues in schools (13% and 33% respectively).

Table 23: Top three suggestions from organisations for further promotion and knowledge sharing facilitation, overall and by organisation types

| Topics | n= | Organisations overall | Peak body / representative non-government orgs | Mental health service provider or non-gov org | NSW Health | Other NSW Government | Research/university sector | Other not-for-profit org | Other |
|---|---|---|---|---|---|---|---|---|---|
| | | 61 | 5 | 10 | 17 | 16 | 0 | 9 | 4 |
| Information dissemination - promotion/ availability of publications/ networks/ forums, etc. | | 25% | 60% | - | 18% | 38% | - | 33% | - |
| Wider collaboration/ consultation - NGOs, private providers, etc. | | 21% | 40% | 30% | 24% | 6% | - | 11% | 50% |
| Media/ general population awareness & advertising | | 20% | - | 30% | 41% | 13% | - | - | - |
| Improved access to services - regional/ rural areas, etc. | | 10% | - | 20% | 12% | - | - | 11% | 25% |
| Lived experience/ user engagement/ consultation | | 7%* | - | 20% | 6% | - | - | 11% | - |
| More contemporary/ innovative approaches | | 3% | - | 10% | - | - | - | - | 25% |
| More resources/ support | | 10% | 20% | - | - | 13% | - | 33% | - |
| Work more with Department of Education/ schools | | 7% | - | - | - | 19% | - | 11% | - |

Some examples of verbatim comments provided by respondents include:

> *"More use of social media and traditional media."* [Peak body / representative non-government organisation]
>
> *"Broader promotion or increased networking of staff could assist with more widespread recognition of the objectives of the Commission."* [Other NSW Government]

*"Facilitate senior level collaboration 'think tanks' with NGOs, government and private providers."* [Mental health service provider or non-government organisation]

*"Increased contact with clinicians. Most contact is via email and while this reaches a lot of people, clinicians are often overwhelmed with information and policies, so engagement with clinicians in other ways would be useful."* [NSW Health]

*"TV advertising, broader use of other mass media."* [Mental health service provider or non-government organisation]

"*Broader service delivery."* [Other not-for-profit organisation]

*"More work with teachers in school on how to respond in a local context."* [Other NSW Government]

Individuals, significantly mostly those with a lived experience of mental illness, thought that the Commission could best promote and facilitate knowledge sharing by consulting with people with lived experience of the issues (28% of individuals overall, 42% of people with lived experience). Health professionals were significantly most likely to suggest more collaboration and consultation across the mental health sector (34%, compared with 21% of individuals overall).

Table 24: Top three suggestions from individuals for further promotion and knowledge sharing facilitation, overall and by individual background

| Topics | n= | Individuals overall | A person with lived experience of mental illness | A family member or carer of a person with mental illness | Health professional | Other professional/ member of the public |
|---|---|---|---|---|---|---|
| | | 123 | 33 | 27 | 50 | 13 |
| Lived experience/ user engagement/ consultation | | 28%* | 42%* | 22% | 20% | 38% |
| Wider collaboration/ consultation - NGOs, private providers, etc. | | 21% | 0%* | 30% | 34%* | 8% |
| Information dissemination - promotion/ availability of publications/ networks/ forums, etc. | | 20% | 21% | 11% | 22% | 23% |
| Media/ general population awareness & | | 19% | 24% | 15% | 16% | 23% |

| Topics | n= | Individuals overall | A person with lived experience of mental illness | A family member or carer of a person with mental illness | Health professional | Other professional/ member of the public |
|---|---|---|---|---|---|---|
| | | 123 | 33 | 27 | 50 | 13 |
| advertising | | | | | | |

Some examples of verbatim comments provided by respondents include:

> *"Put 'lived experience at the heart of mental health reform', to quote your own words … this can only happen when the consumer voice is equal to clinicians."* [A person with lived experience of mental illness]
>
> *"More collaboration with other organisations."* [Health professional]
>
> *"The MHC needs to engage with better with LHDs and clinicians."* [Health professional]
>
> *"Partner with community organizations and cultural groups to hold programs that facilitate the sharing of knowledge about mental health issues."* [Other professional]
>
> *"Hold community education sessions for service uses and carers, to better understand diagnoses and treatment options. Better education of frontline GPs and health care services available for referrals. Increased support for NSW education in the early detection and referral pathways. Increase education of all non-medication treatment plans, focusing on behavioural training and self-monitoring/regulation and cognitive behavioural support."* [Other professional]

Two of the four Aboriginal respondents mostly encouraged additional consultation with people with a lived experience of mental illness (50%).

Table 25: Top three suggestions for further promotion and knowledge sharing facilitation, by Aboriginal and Torres Strait Islander origin

| Topics n= | Aboriginal 4 | Not Aboriginal 117 |
|---|---|---|
| Wider collaboration/ consultation - NGOs, private providers, etc. | 25% | 21% |
| Lived experience/ user engagement/ consultation | 50% | 26% |
| Media/ general population awareness & advertising | 25% | 19% |
| More contemporary/ innovative approaches | 25% | 1% |
| Information dissemination - promotion/ availability of publications/ networks/ forums, etc. | - | 21% |

Some examples of verbatim comments provided by respondents include:

ABORIGINAL AND TORRES STRAIT ISLANDERS:

> *"Consult with users, not NGOs."* [A person with lived experience of mental illness]
>
> *"Work more with families and carers. LISTEN MORE!"* [A family member or carer of a person with mental illness]
>
> *"Advertising, promotion of services, more funding."* [A family member or carer of a person with mental illness]

Of the CALD segments, respondents born overseas, who spoke a language other than English at home, were most keen for the Commission to engage and consult with people with a lived experience of mental illness to further promote and facilitate knowledge sharing (50%).

Table 26: Top three impacts suggestions for further promotion and knowledge sharing facilitation, by culturally and linguistically diverse categories

| Topics | n= | Born in Australia, speaks English at home: 85 | Born in Australia, speaks language other than English at home: 5 | Born overseas, speaks English at home: 18 | Born overseas, speaks language other than English at home: 12 |
|---|---|---|---|---|---|
| Lived experience/ user engagement/ consultation | | 29% | - | 17% | 50% |
| Media/ general population awareness & advertising | | 20% | 20% | 22% | 8% |
| Wider collaboration/ consultation - NGOs, private providers, etc. | | 20% | - | 28% | 25% |
| Information dissemination - promotion/ availability of publications/ networks/ forums, etc. | | 19% | 20% | 22% | 25% |
| Work more with Department of Education/ schools | | 4% | 20% | - | - |
| More resources/ support | | 12% | 20% | 11% | 8% |
| Address/ reduce stigma | | 6% | 60% | 6% | 8% |

Some examples of verbatim comments provided by respondents include:

BORN IN AUSTRALIA, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

> *"At times, news reports will include perpetrators of violence or crime as 'having a mental illness'. This is stigmatising. Maybe when this occurs, if the Commission could provide a balanced view."* [A family member or carer of a person with mental illness]
>
> *"Have more PSIs which could not only empower people but also assist to reduce the stigma and preconceived ideas of mental health issues."* [A person with lived experience of mental illness]

*"Health marketing in live program screening, for example, advertising on SBS."* [Health professional]

"*Have a program in high school for students to recognise mental health issues, either for themselves, or family members."* [Member of the public (none of the above)]

BORN OVERSEAS, SPEAKS ENGLISH AT HOME:

*"Collaborate more. Involve key mental health policy people in the work of the Commission."* [Health professional]

*"Establish a newsletter. Publish more information about how carers and consumers are involved in the planning and implementation of evidenced-based mental health in NSW."* [Health professional]

"*Hold weekly education sessions on depression at all libraries*." [A family member or carer of a person with mental illness]

*"Real engagement with social media would be a good strategy*." [Health professional]

*"It would be better if the information were presented in short videos so that information could be used by health professionals and regular members of the community."* [Health professional]

BORN OVERSEAS, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

*"Partner with community organisations and cultural groups to hold programs that facilitate the sharing of knowledge about mental health issues. More needs to be done at a grassroots or community level regarding mental health*." [Other professional]

*"Focus on inclusiveness by developing stronger connections with groups, organisations and individuals. Increased visibility in the community and more interaction with CALD communities and their representatives. Work with 'them', instead of working for 'them'."* [A family member or carer of a person with mental illness]

Respondents away from major cities wanted promotion and education services to especially reach people in regional and remote areas (33% of outer regional/ remote respondents, 15% of inner regional respondents). Inner regional respondents also wanted more general publicity of mental health issues, to educate the wider community, beyond those already involved with mental health services, programs or issues (21%), while outer

regional/ remote respondents also sought additional resourcing for actual support services, saying that increased knowledge was not enough on its own (22%).

Table 27: Top three suggestions for further promotion and knowledge sharing facilitation, overall and by remoteness category

| Topics n= | Overall 184 | Major cities 121 | Inner regional 34 | Outer regional / remote 9 |
|---|---|---|---|---|
| Lived experience/ user engagement/ consultation | 21% | 21% | 26% | 33% |
| Information dissemination - promotion/ availability of publications/ networks/ forums, etc. | 21% | 22% | 12% | 22% |
| Wider collaboration/ consultation - NGOs, private providers, etc. | 21% | 22% | 15% | 22% |
| Improved access to services - regional/ rural areas, etc. | 9% | 6% | 15% | 33% |
| Media/ general population awareness & advertising | 19% | 18% | 21% | 11% |
| More resources/ support | 11% | 12% | 9% | 22% |

Some examples of verbatim comments provided by respondents include:

MAJOR CITIES:

> *"Expand the information [available] and education in schools, as this is where most Australian children will spend the majority of their formative years. Early education about mental health issues would be my recommendation."* [Other professional]
>
> *"Instead of investing in flyers, that people don't read or make use of.... please have audio representations so we can play them on our TV whilst clients are waiting at the reception to be served."* [Peak body / representative non-government organisation]
>
> *"Collaborate more. Involve key mental health policy people in the work of the Commission."* [Health professional]
>
> *"They should actively involve themselves in issues and projects at local levels. For example, the local roll outs of Mental Health Month."* [Other]
>
> *"Talk to people with lived experience, not just those chosen as mouthpieces for services. Talk to homeless people and people who can't engage with programs."* [A person with lived experience of mental illness]

INNER REGIONAL:

*"Consult with [service] users, not NGOs."* [A person with lived experience of mental illness]

*"They need to speak with clients and family members who are affected on a regular basis by the lack of facilities available to those with mental illness."* [A family member or carer of a person with mental illness]

*"Promote the organisation and what it does more widely, for example, to NSW health staff working in mental health."* [Health professional]

*"Get out there and talk with teams of services across the state."* [NSW Health]

*"Promote better access to regional and rural psychiatric and psychological services."* [A family member or carer of a person with mental illness]

OUTER REGIONAL/REMOTE:

*"More use of those with lived experiences."* [Health professional]

*"I've suffered with mental health issues for 29 years and have never heard of the Mental Health Commission… Rural areas need serious attention and better services."* [A person with lived experience of mental illness]

*"Interact more locally with service providers, particularly in rural areas."* [Mental health service provider or non-government organisation]

*"There is an increased awareness, but significant stigma remains. Knowledge and awareness doesn't equal adequate assistance for mental health sufferers and their carers/family."* [A person with lived experience of mental illness]

### 5.3.3 Examples of the Mental Health Commission's promotion and facilitation of knowledge sharing

From respondents who agreed or strongly agreed that the Commission had effectively promoted and facilitated knowledge sharing about mental health issues, the online consultation survey sought examples from the last five years that best showed how the Commission had done so.

A fifth of respondents expressed positive sentiments about with the meetings, conference, workshops and presentations that the Commission had initiated (20%). A fifth also commended the Commission on its papers and other publications, including those that it had made publicly accessible on its website (19%). Individuals from both segments were most likely to highlight the effectiveness of publicly available information and resources

(25%); as were submissions from NSW Government (23%). NSW Government respondents also felt that the Commission had been successful in the development of other specific programmes, and the incorporation of lived experience (both 13%).

Table 28: Top three examples of promotion and knowledge sharing facilitation, overall and by high level organisation and individual groupings

| Topics | n= | Overall 185 | NSW Government organisations 47 | Other organisations 49 | People with lived experience of mental illness and their families and carers 36 | Health professionals and other individuals 53 |
|---|---|---|---|---|---|---|
| Meetings/ conferences clarifying/ promoting MHC | | 20% | 17% | 22% | 17% | 23% |
| (More) publicly available information/ resources | | 19% | 23% | 4% | 25% | 25% |
| Advisory forums/ groups | | 10% | 6% | 12% | 17% | 6% |
| Support/ development of other specific programmes/ strategies | | 10% | 13% | 14% | 6% | 8% |
| Reflecting/ incorporating lived experiences | | 6% | 13% | 10% | 3% | - |
| Engaging all stakeholders | | 8% | 6% | 12% | 3% | 8% |
| Living Well | | 6% | 4% | 2% | 6% | 11% |
| Commissioner's profile/ public activity/ advocacy | | 6% | 4% | 12% | 6% | 4% |

As well as praising the meetings and conferences it ran, and the information material it made available, organisations often mentioned specific programs or strategies the Commission had developed or supported, such as:

- bringing the International Mental Health Leadership program to Australia
- a strategic direction in relation to treating people with trauma
- supporting the Gayaa Dhuwi (Proud Spirit) Declaration
- specific health programs for specific community groups
- support for the Consumer Led Research Network.

Fourteen percent of organisations overall mentioned these sorts of programs and strategies (14%), ranging from 11% of peak bodies/ representative non-government organisations, 'other' NSW government, and 'other' organisations, to 31% of respondents from NSW Health, as listed in Table 29.

Table 29: Top three examples of promotion and knowledge sharing facilitation from organisations, overall and by organisation types

| Topics | n= | Organisations overall 96 | Peak body / representative non-government orgs 9 | Mental health service provider or non-gov org 20 | NSW Health 29 | Other NSW Government 18 | Research/university sector 5 | Other not-for-profit org 6 | Other 9 |
|---|---|---|---|---|---|---|---|---|---|
| Meetings/ conferences clarifying/ promoting MHC | | 20% | 11% | 20% | 14% | 22% | 20% | - | 56% |
| (More) publicly available information/ resources | | 14% | 11% | - | 31% | 11% | - | - | 11% |
| Support/ development of other specific programs/ strategies | | 14% | 11% | 20% | 14% | 11% | - | 17% | 11% |
| Newsletters/ news subscriptions | | 5% | 11% | 5% | 10% | - | - | - | - |
| Advisory forums/ groups | | 9% | 22% | 10% | 3% | 11% | - | 33% | - |
| On-line resources - reports/ forums/ social media, etc. | | 6% | - | 15% | 10% | - | - | - | - |
| Reflecting/ incorporating lived experiences | | 11%* | - | 5% | 14% | 11% | - | 17% | 33% |
| Engaging all stakeholders | | 9% | 11% | 15% | 3% | 11% | 20% | 17% | - |
| Wellbeing collaborative/ cross-organisational wellbeing support/ development/ IIMHL | | 8% | 11% | 5% | 3% | 17% | 20% | - | 11% |
| Suicide Prevention & Support | | 4% | 11% | - | - | 11% | - | - | 11% |
| R U OK? | | 1% | 11% | - | - | - | - | - | - |
| Commissioner's profile/ public activity/ advocacy | | 8% | - | 15% | 7% | - | 20% | 17% | 11% |

| Topics | n= | Organisations overall | Peak body / representative non-government orgs | Mental health service provider or non-gov org | NSW Health | Other NSW Government | Research/university sector | Other not-for-profit org | Other |
|---|---|---|---|---|---|---|---|---|---|
| | | 96 | 9 | 20 | 29 | 18 | 5 | 6 | 9 |
| Emergency Services | | 1% | - | - | - | - | - | - | 11% |

Some examples of verbatim comments provided by respondents include:

> *"Workshops hosted by the Commission attended by departmental staff."* [Other NSW Government]
>
> *"Collaborative and effective meetings around suicide prevention across sectors as diverse as police, ambulance, [people with] lived experience, primary health care networks, etc."* [Other]
>
> *"Conferences and media."* [NSW Health]
>
> *"Engagement with health services regarding PIR and NDIS implementation. NSW has been slow to prepare, and the Commissioner has reminded us of this."* [Mental health service provider or non-government organisation]
>
> *"I have been in meetings where they have represented the needs of people with lived experience in a way which advocated and raised awareness."* [NSW Health]
>
> *"The Wellbeing Collaborative has facilitated knowledge sharing around mental health issues … it successfully brought together government and NGOs to discuss mental health issues in NSW."* [Other NSW Government]
>
> *"The Commission is very visible as an actor at events and meetings and does not just listen, but creates new knowledge through discussions and opinions."* [Research/university sector]

Individuals, especially family members and carers, were happy with the information and education resources the Commission had made available to them and other members of the public (25% individuals overall, 32% family members or carers). Health professionals and

'other' professionals/ members of the public also valued the information resources (24% and 25% respectively), but also particularly appreciated the meetings and conferences that the Commission had run (22% and 25% respectively). (See Table 30.)

Table 30: Top three examples of promotion and knowledge sharing facilitation from individuals, overall and by individual background

| Topics | n= | Individuals overall | A person with lived experience of mental illness | A family member or carer of a person with mental illness | Health professional | Other professional/ member of the public |
|---|---|---|---|---|---|---|
| | | 89 | 11 | 25 | 41 | 12 |
| (More) publicly available information/ resources | | 25% | 9% | 32% | 24% | 25% |
| Meetings/ conferences clarifying/ promoting MHC | | 20% | 18% | 16% | 22% | 25% |
| Advisory forums/ groups | | 10% | 9% | 20% | 5% | 8% |
| Newsletters/ news subscriptions | | 6% | 18% | - | 5% | 8% |
| On-line resources - reports/ forums/ social media, etc. | | 9% | 9% | 8% | 10% | 8% |
| Engaging all stakeholders | | 6% | - | 4% | 7% | 8% |
| Wellbeing collaborative/ cross-organisational wellbeing support/ development/ IIMHL | | 4% | 18% | - | 2% | 8% |
| Living Well | | 9% | 9% | 4% | 12% | 8% |
| R U OK? | | 2% | - | 4% | - | 8% |
| Emergency Services | | 1% | - | - | - | 8% |

Some examples of verbatim comments provided by respondents include:

> *"Information made available to the public."* [Health professional]
>
> *"Publications that are available online and have been discussed at various meetings."* [A family member or carer of a person with mental illness]
>
> *"Commissioners have been great at conferences promoting understanding and openness of mental health issues."* [Health professional]

*"Some of the forums were informative."* [Other professional]

*"I read their newsletters or have seen something on Facebook."* [A person with lived experience of mental illness]

*"The excellent IIMHL meetings provided wonderful opportunities for people in NSW to learn and share knowledge."* [Member of the public (none of the above)]

Two of the three Aboriginal respondents also commented on the information resources the Commission had made available (67%). (See Table 31.)

Table 31: Top three examples of promotion and knowledge sharing facilitation, by Aboriginal and Torres Strait Islander origin

| Topics n= | Aboriginal 3 | Not Aboriginal 86 |
|---|---|---|
| (More) publicly available information/ resources | 67% | 23% |
| On-line resources - reports/ forums/ social media, etc. | - | 9% |
| Support/ development of other specific programs/ strategies | - | 7% |
| Other | - | 6% |
| Advisory forums/ groups | - | 10% |
| Meetings/ conferences clarifying/ promoting MHC | - | 21% |
| Check Up From the Neck-Up | 33% | - |

Some examples of verbatim comments provided by respondents include:

ABORIGINAL AND TORRES STRAIT ISLANDERS:

*"Advertising about building healthy relationships and depression."* [Health professional]

*"Check-up from the Neck-up."* [A person with lived experience of mental illness]

Publicly available information resources were, again, frequently mentioned by the two CALD groups of people born overseas, as examples of the Commission's promotion and facilitation of knowledge sharing (29% of those speaking a language other than English at home, 21% of those speaking English at home), as well as by Australian born, English speakers (27%). However, the two groups born overseas also quite frequently mentioned the Commission's online and multi-media resources as good examples, such as those shared by

webinar, or social media (14% of those speaking a language other than English at home, 16% of those speaking English at home). The findings for CALD groups are listed in Table 32.

Table 32: Top three examples of promotion and knowledge sharing facilitation, by culturally and linguistically diverse categories

| Topics | n= | Born in Australia, speaks English at home: 59 | Born in Australia, speaks language other than English at home: 4 | Born overseas, speaks English at home: 19 | Born overseas, speaks language other than English at home: 7 |
|---|---|---|---|---|---|
| (More) publicly available information/ resources | | 27% | - | 21% | 29% |
| Meetings/ conferences clarifying/ promoting MHC | | 20% | 25% | 21% | 14% |
| Advisory forums/ groups | | 12% | - | 5% | 14% |
| Newsletters/ news subscriptions | | 5% | 25% | - | 14% |
| On-line resources - reports/ forums/ social media, etc. | | 7% | - | 16% | 14% |
| Support/ development of other specific programs/ strategies | | 7% | 25% | 5% | - |
| Living Well | | 8% | 25% | 5% | 14% |

Some examples of verbatim comments provided by respondents include:

BORN IN AUSTRALIA, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

> *"Commissioners have been great at conferences promoting understanding and openness of mental health issues."* [Health professional]
>
> *"Newsletter subscriptions."* [A person with lived experience of mental illness]
>
> *"Their report Living Well."* [Other professional]

BORN OVERSEAS, SPEAKS ENGLISH AT HOME:

*"The MHC set up a working or advisory group with carers; they held forums asking that specific group about their needs, etc. It is a good example of how they attack an issue by recognising they need to ask the specific group to clarify the issues, then ask for solutions."* [A family member or carer of a person with mental illness]

*"The parliamentary launch of the MHC's report on the justice system."* [Other professional]

*"Holding forums and workshops where [people with] lived experience [of mental illness] could participate."* [A person with lived experience of mental illness]

*"I have found the emails informative."* [Health professional]

BORN OVERSEAS, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

*"I gained more information and access to services in my region, so that I can refer carers and people with mental illness."* [Other professional]

*"The Mental Health Commission forum day in Sydney two years ago."* [A family member or carer of a person with mental illness]

*"I received several emails from the MHC about their activities, as well as their reports."* [Other professional]

*"I receive informed emails from a Carer Advocate … about where to attend workshops and training regarding knowledge around mental illness."* [A family member or carer of a person with mental illness]

*"The Living Well plan."* [A person with lived experience of mental illness]

The Commission's newsletters and email updates, and its stakeholder engagement efforts, were especially appreciated by inner regional respondents (14% each).

Table 33: Top three examples of promotion and knowledge sharing facilitation, overall and by remoteness category

| Topics | n= | Overall<br>185 | Major cities<br>130 | Inner regional<br>29 | Outer regional / remote<br>6 |
|---|---|---|---|---|---|
| Meetings/ conferences clarifying/ promoting MHC | | 20% | 21% | 14% | - |
| (More) publicly available information/ resources | | 19% | 17% | 24% | 33% |
| Advisory forums/ groups | | 10% | 8% | 10% | 17% |

| Topics n= | Overall 185 | Major cities 130 | Inner regional 29 | Outer regional / remote 6 |
|---|---|---|---|---|
| Support/ development of other specific programs/ strategies | 10% | 11% | 3% | 17% |
| Newsletters/ news subscriptions | 5% | 3%* | 14% | - |
| Engaging all stakeholders | 8% | 8% | 14% | - |
| Suicide Prevention & Support | 2% | 2% | - | 17% |
| Living Well | 6% | 5% | 3% | 17% |
| Commissioner's profile/ public activity/ advocacy | 6% | 8% | 3% | 17% |

Some examples of verbatim comments provided by respondents include:

MAJOR CITIES:

*"The Mental Health Service Conference."* [A family member or carer of a person with mental illness]

*"Meeting with the Commissioner to discuss challenges, opportunities and services currently available along with gaps."* [Mental health service provider or non-government organisation]

*"The website has information on mental health and CALD communities."* [NSW Health]

*"The establishment of specific health programs for specific community groups."* [Other]

INNER REGIONAL:

*"It has provided good news stories, and promoted individual endeavour."* [Health professional]

*"Media interviews."* [NSW Health]

*"The MH Commission visits are helpful."* [Health professional]

*"The newsletters from the Commissioner."* [Mental health service provider or non-government organisation]

*"Through visiting non-government organisations and talking to frontline staff."* [Other not-for-profit organisation]

OUTER REGIONAL/REMOTE:

*"TV awareness campaigns."* [Health professional]

*"Organisation of community forums."* [Health professional]

*"The NSW MHC's 'A Caring Collective' forum for carers and families of those with mental illness, conducted in August 2017."* [A family member or carer of a person with mental illness]

*"An increased focus on and support of Suicide Support services."* [Other NSW Government]

*"The enormous consultation and feedback process about Living Well."* [Health professional]

## 5.4 Research, innovation and policy development

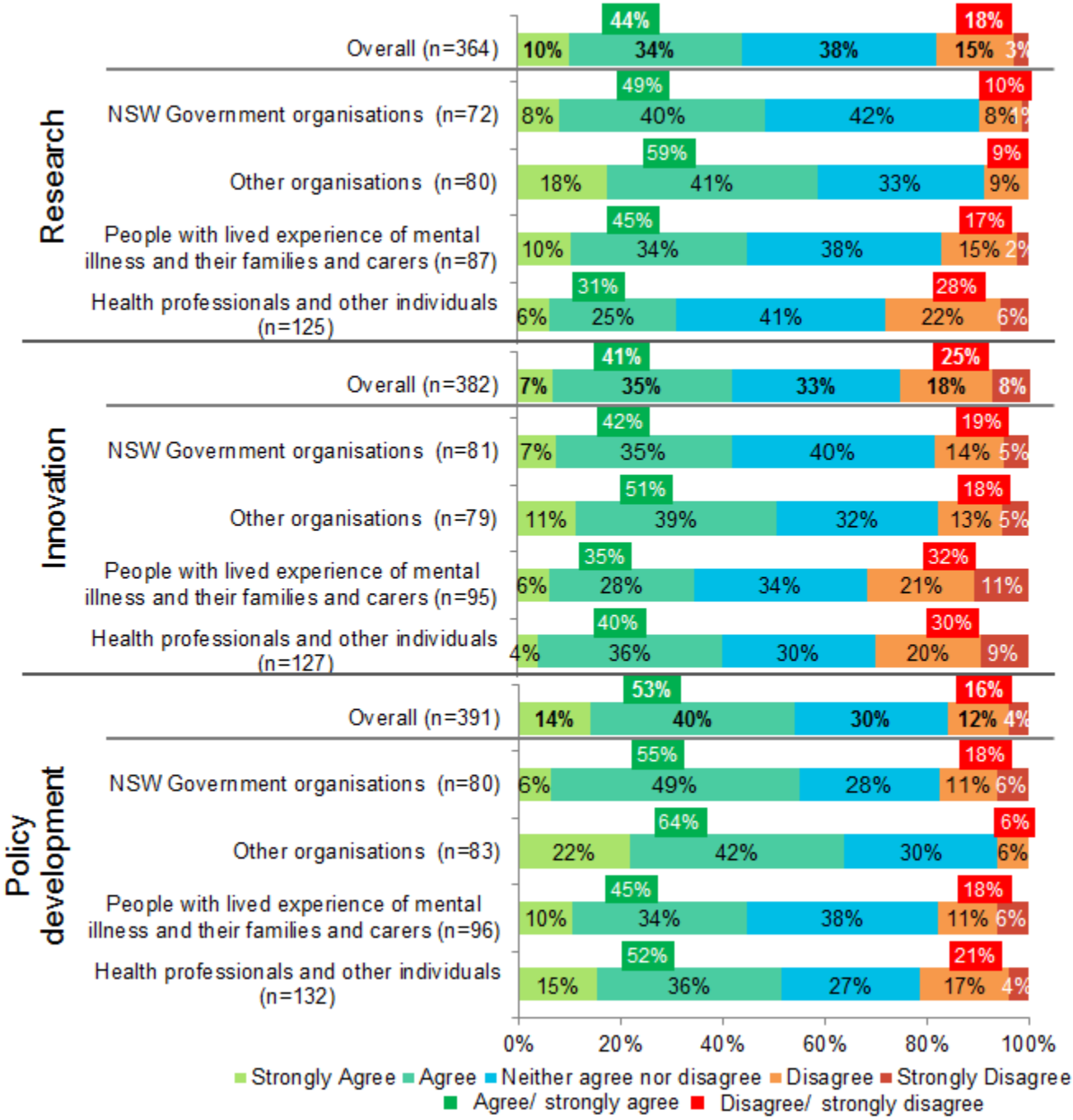
Under the Act, the Mental Health Commission's fifth function was to *undertake and commission research, innovation and policy development in relation to mental health issues*.

### 5.4.1 Research, innovation and policy development

Overall, 44% of respondents agreed/ strongly agreed that the Commission had undertaken research effectively; and 41% agreed/ strongly agreed that it had undertaken innovation effectively. Respondents were generally more positive about the Commission's policy development work, with more than half agreeing/ strongly agreeing with its effectiveness in this function area (53%).

The pattern of findings was similar across these three attitude statements. People with lived experience and their carers were the least positive; submissions from NSW government and other organisations were the most positive. The remaining group of individuals (including health professionals) tended to fall somewhere in between the two. Of note, the only exception to this was that health professionals/other individuals were the least likely to feel that the Commission had been effective in its research (31% - compared with 44% overall).

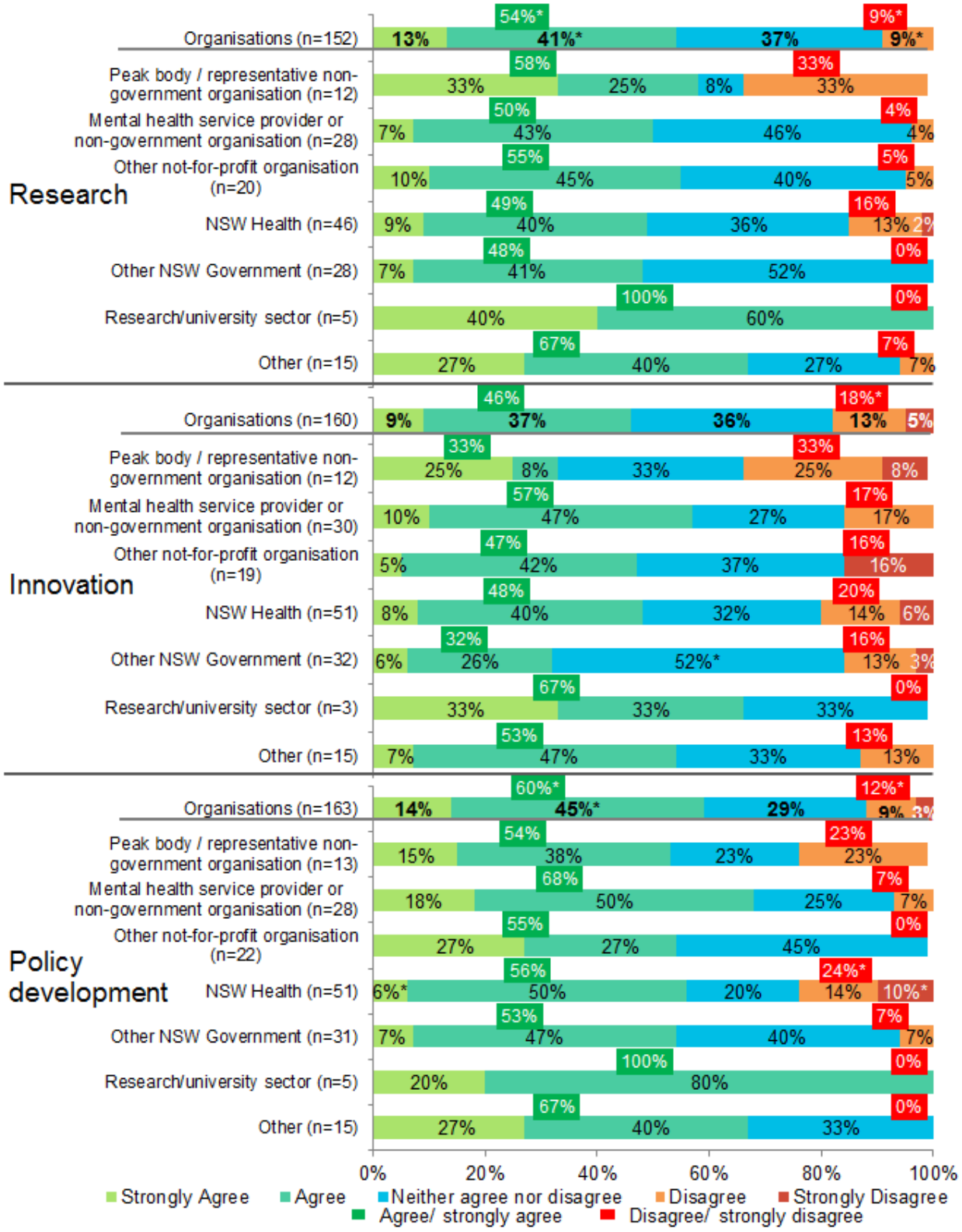
Figure 47: Level of agreement that the Commission effectively undertook *research, innovation, and policy development*, overall and by high level organisation and individual groupings (n=391)



As with many of the findings to previous questions, a significantly higher proportion of organisations than individuals were positive about the effectiveness of the Commission's research and policy development work, agreeing/ strongly agreeing when asked about these function areas (54% regarding research, 60% regarding policy development). A higher proportion of organisations also agreed/ strongly agreed to the effectiveness of the Commission's innovation work (46%), but the difference from the proportion of respondents overall was not significant in this case.

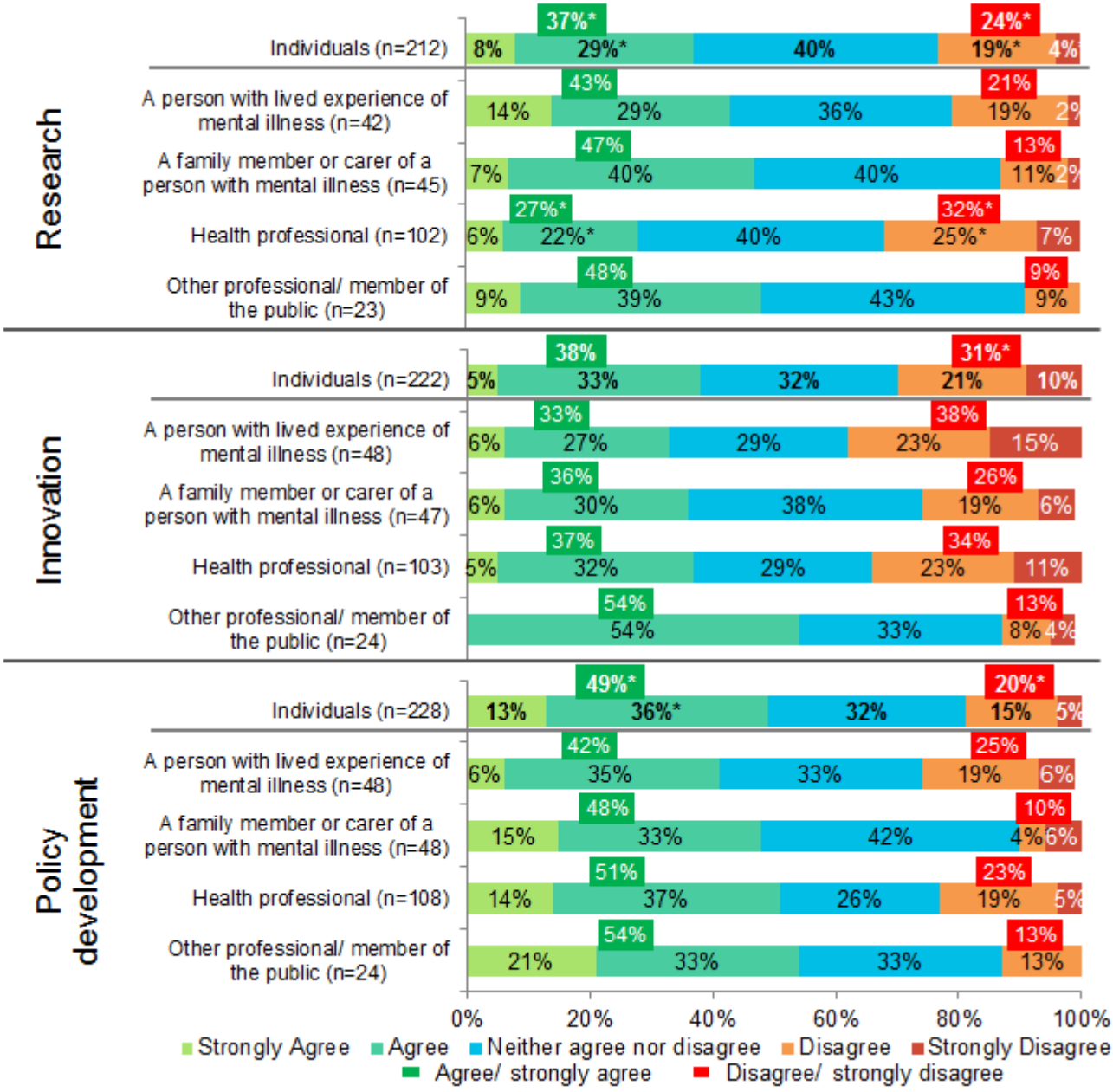
The only significant differences in the agreement ratings given to the effectiveness of the Commission's research, innovation and policy development activities by the different organisation types were in those given by NSW Health regarding policy development. In this area, only 6% of NSW Health respondents strongly agreed (compared to 7%-27% of other organisation types), while they simultaneously displayed the highest proportion of strongly disagree (10%, compared with 0% of all other organisation types) and the highest proportion of disagree/ strongly disagree (24%, compared with 0%-23% of other organisation types). (See Figure 48.)

Figure 48: Organisations' level of agreement that the Commission effectively undertook *research, innovation, and policy development*, overall and by organisation type (n=163)



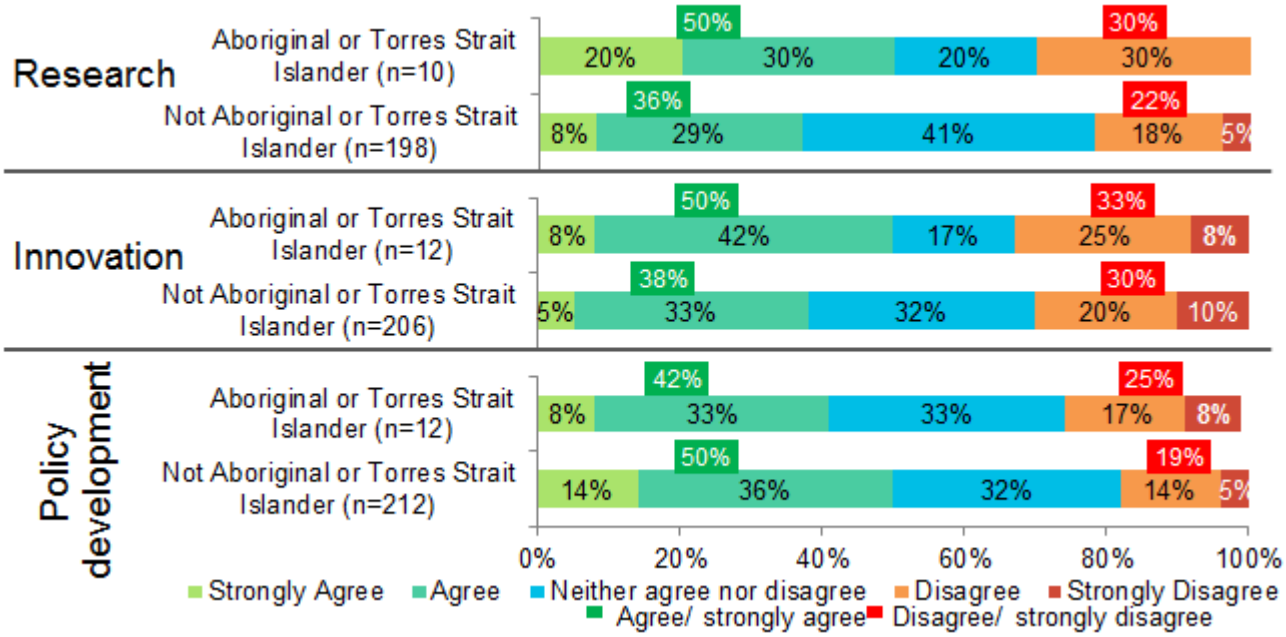
A third to a half of individuals agreed/ strongly agreed with the effectiveness of the Commission's research (37%), innovation (38%), and policy development undertakings (49%). As shown in Figure 49, health professionals' assessment of the effectiveness of the Commission's research was significantly lower than other individuals', with 27% agreeing/ strongly agreeing and 32% disagreeing/ strongly disagreeing that the research had been effectively undertaken.

Figure 49: Individuals' level of agreement that the Commission effectively undertook *research, innovation, and policy development*, overall and by individual background (n=228)



There were no significant differences between Aboriginal and non-Aboriginal respondents, as shown in Figure 50; although there was a minor difference by function area, whereby more Aboriginal respondents considered the Commission's research and innovation to have been effective (50% agreeing/ strongly agreeing to each of these, compared with 36%-38% of non-Aboriginal respondents), and, conversely, more non-Aboriginal respondents thought that the Commission's policy development had been effective (50% agreed/ strongly agreed, compared with 42% of non-Aboriginal respondents).

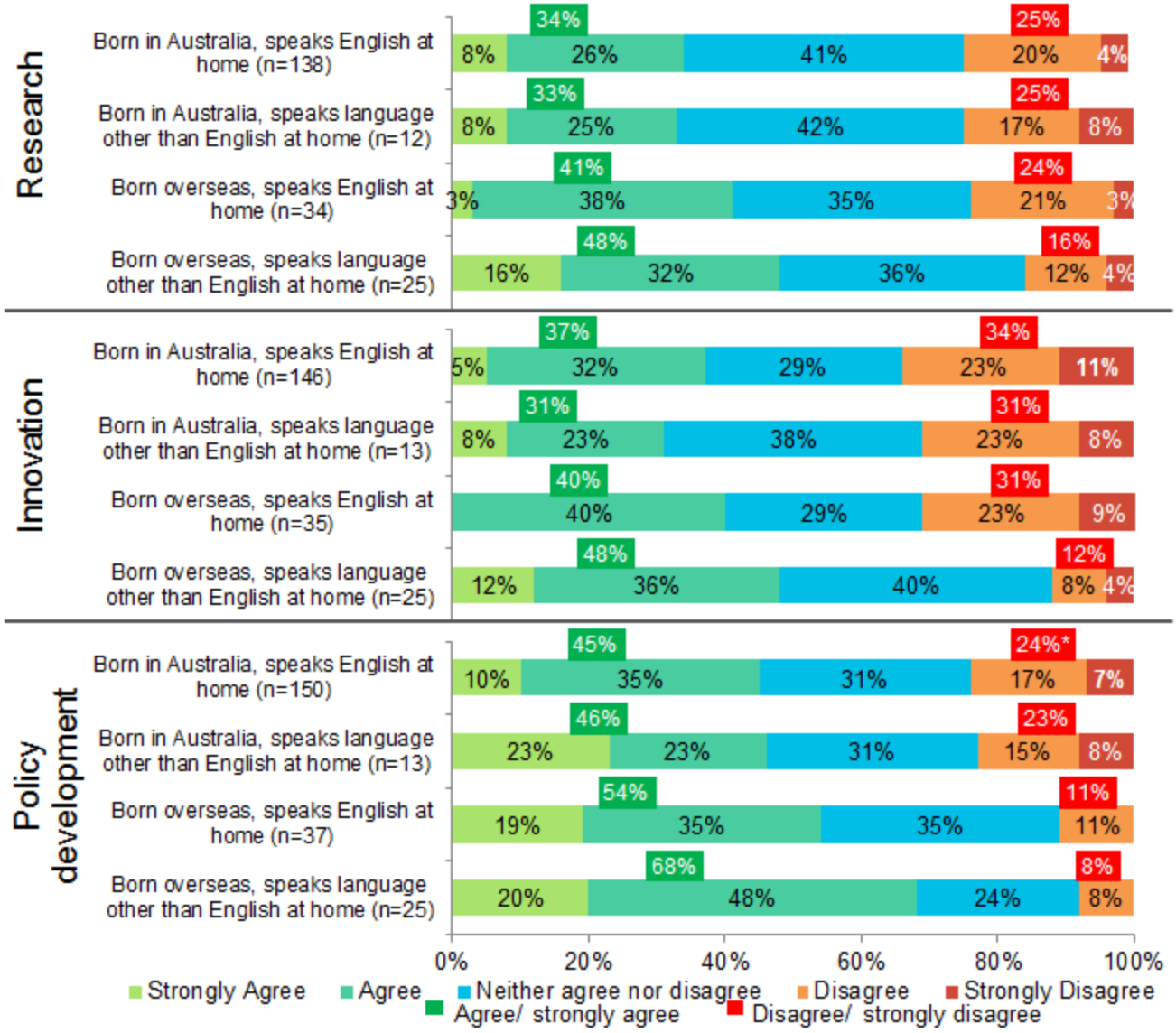
Figure 50: Level of agreement that the Commission effectively undertook *research, innovation, and policy development*, by Aboriginal and Torres Strait Islander origin (n=224)




Policy development was also the only one of the three specified areas for which CALD groups differed in opinion, as respondents born in Australia, who spoke English at home, had the largest, and significantly different, proportion who disagreed/ strongly disagreed that the Commission's policy development undertakings had been effective (24%, compared with 8%-23% of other CALD groups). Respondents born overseas, who spoke a language other than English at home had the highest (not significantly different) proportion who agreed/ strongly agreed that the policy development had been effective (68%, compared with 45%-54% of other CALD groups).

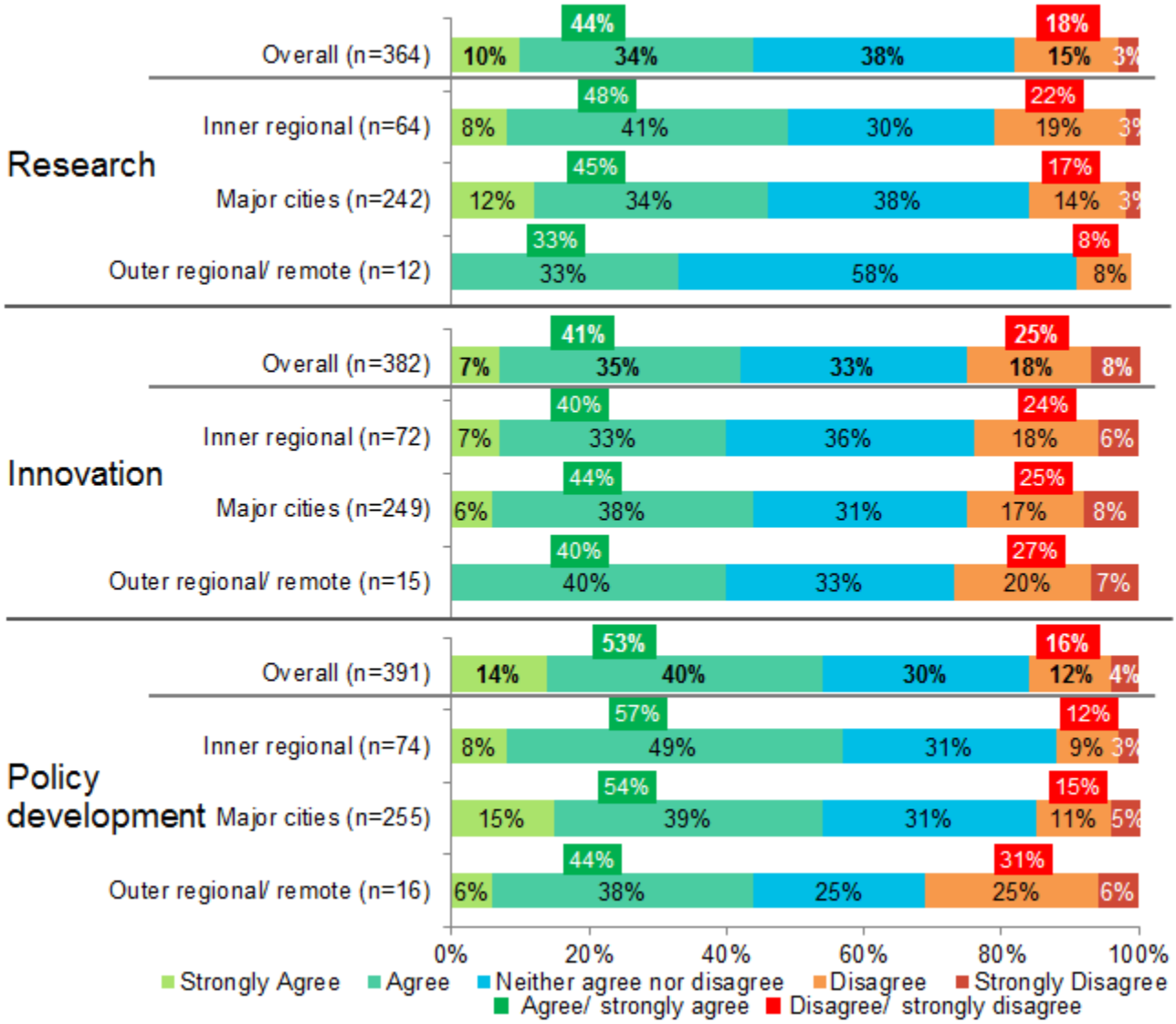
The agreement level results by CALD group are given in Figure 51.

Figure 51: Level of agreement that the Commission effectively undertook *research, innovation, and policy development*, by culturally and linguistically diverse categories (n=225)



As shown in Figure 52, differences between the agreement ratings given to these three function areas by respondents from each remoteness category were minimal, and not statistically significant, but the twelve respondents from outer regional/ remote regions were most ambivalent about the effectiveness of the Commission's research undertakings (58% neither agreed nor disagreed, compared with 30% and 38% of respondents from inner regional and major city areas, respectively).

Figure 52: Level of agreement that the Commission effectively undertook *research, innovation, and policy development*, overall and by remoteness category (n=391)



## 5.4.2 The impact of the Mental Health Commission's research, innovation, policy development and education initiatives

Respondents who had given any rating to any of the previous questions about the effectiveness of the Commission's research, innovation, policy development, or education initiatives were asked to give an example of one of these, and to describe the impact that it had had on the mental health sector or the mental health and wellbeing of the people of New South Wales.

A fifth of respondents believed that there had been little concrete impact on service provision, nor that there was any evidence of direct effects on individuals (20%). However, 15% were positive about the policy focus on community engagement and person-centred care, and the widening of health care approaches to allow an "open dialogue" which considers the views of the person with mental illness, as well as their families and carers, and concentrates on care and recovery, rather than simply "custodial care" for mentally ill people. Many respondents also spoke positively about many of the Commission's communications activities, including its brochures, reports and other research and educations materials and the media campaigns to raise awareness of issues in the wider community (11%). People with lived experience of mental illness/carers were most likely to articulate negative comments (31%) and to discuss communications aimed at raising public awareness (23%).

Table 34: Top three research, innovation, policy development, or education initiatives, overall and by high level organisation and individual groupings

| Topics | n= | Overall<br>184 | NSW Government organisations<br>43 | Other organisations<br>39 | People with lived experience of mental illness and their families and carers<br>39 | Health professionals and other individuals<br>63 |
|---|---|---|---|---|---|---|
| Negative comments on impacts | | 20% | 19% | 3% | 31% | 24% |
| Community focus/ engagement | | 15% | 19% | 23% | 5% | 14% |
| Communications raising public awareness | | 11% | 9% | 13% | 23% | 5% |

| Topics | n= | Overall 184 | NSW Government organisations 43 | Other organisations 39 | People with lived experience of mental illness and their families and carers 39 | Health professionals and other individuals 63 |
|---|---|---|---|---|---|---|
| The Wellbeing Collaborative | | 4% | 12% | - | 3% | 3% |
| Establishment/ encouragement of peer networks | | 7% | 7% | 5% | 8% | 8% |
| Living Well promotion/ program | | 8% | 7% | 8% | - | 13% |
| Funded/ supported/ partnered in research/ development programs & projects | | 5% | - | 13% | 3% | 5% |

Organisations were significantly less negative about the limitations of the impacts than individuals (11% of organisations overall, 26% of individuals overall), although 22% of NSW Health respondents thought there was "little 'on the ground' change." A fifth of organisations were positive about the Commission having sought input from people with exposure to mental illness by, "going to communities and really listening, doing qualitative research, [and] the phone-in, [which provided] an excellent opportunity for those affected to feel heard" (21% of organisations overall, ranging from 17% of 'other' organisations to 33% of 'other' not-for-profit organisations)[18]. A fifth of mental health service providers or non-government organisations spoke highly of the way the Commission's communications had helped raise public awareness of mental health issues (20%). (See Table 35.)

[18] And none of the five research/ university sector respondents (0%).

Table 35: Top three research, innovation, policy development, or education initiatives mentioned by organisations, overall and by organisation types

| Topics | n= | Organisations overall 82 | Peak body / representative non-government orgs 7 | Mental health service provider or non-gov org 15 | NSW Health 27 | Other NSW Government 16 | Research/university sector 5 | Other not-for-profit org 6 | Other 6 |
|---|---|---|---|---|---|---|---|---|---|
| Community focus/ engagement | | 21% | 29% | 27% | 19% | 19% | - | 33% | 17% |
| Communications raising public awareness | | 11% | - | 20% | 7% | 13% | - | 17% | 17% |
| Negative comments on impacts | | 11%* | - | 7% | 22% | 13% | - | - | - |
| Establishment/ encouragement of peer networks | | 6% | 14% | 7% | 11% | - | - | - | - |
| Living Well promotion/ program | | 7% | - | 13% | 11% | - | - | 17% | - |
| Collaboration/ consultation - NGO's, private providers, etc. | | 4% | 14% | - | - | - | 20% | 17% | - |
| Suicide Prevention and Support | | 7% | 14% | 7% | 7% | - | - | - | 33% |
| The Wellbeing Collaborative | | 6% | - | - | - | 31% | - | - | - |
| Youth/ young adult focus | | 6% | - | 7% | - | 19% | - | 17% | - |
| General positive comments | | 2% | 14% | - | 4% | - | - | - | - |
| Funded/ supported/ partnered in research/ development programs & projects | | 6% | - | - | - | - | 60% | 17% | 17% |

Some examples of verbatim comments provided by respondents include:

> *"Work with communities."* [Other NSW Government]
>
> *"Engagement of people with lived experience of mental health to guide current and future service objectives."* [Mental health service provider or non-government organisation]

*"The Commission has probably increased political awareness of the issues and there have been some important shifts in community awareness of issues like depression and anxiety."* [Other not-for-profit organisation]

*"Nothing - the document comes across as aimless and nebulous."* [NSW Health]

*"The Commission has undertaken some good research around peer workers and set up the Peer Hub as an effective way to promote the use of such workers. We have been able to refer services and researchers to the Peer Hub website and repository of information and templates and this has helped us to promote the use of peer workers and to explain their appropriate roles in care delivery."* [Peak body / representative non-government organisation]

*"The provision of the Living Well documents and continuing advocacy from the Commission in raising and maintaining a focus on mental health issues in the public arena."* [NSW Health]

*"The IIMHL exchanges fostered international learning in many aspects of mental health practice with world leaders."* [Research/university sector]

As listed in Table 36, a quarter of individuals overall (26%), and 30% to 32% of people with lived experience of mental illness, and their families and carers, could see little impact arising directly out of the Commission's work, not being able to "think of any [impacts to] attach specifically to the Commission - it's pretty invisible." Health professionals spoke significant less often about the positive effects on public awareness from the Commission's communications (2%, compared with 15% to 30% of individuals from other backgrounds), but had a lot of respect for *Living Well*, specifically mentioning it significantly more often than other individuals, who did not name it at all here (16%).

Table 36: Top three research, innovation, policy development, or education initiatives mentioned by individuals, overall and by individual background

| Topics | n= | Individuals overall | A person with lived experience of mental illness | A family member or carer of a person with mental illness | Health professional | Other professional/ member of the public |
|---|---|---|---|---|---|---|
| | | 102 | 20 | 19 | 50 | 13 |

| Topics n= | Individuals overall 102 | A person with lived experience of mental illness 20 | A family member or carer of a person with mental illness 19 | Health professional 50 | Other professional/ member of the public 13 |
|---|---|---|---|---|---|
| Negative comments on impacts | 26%* | 30% | 32% | 28% | 8% |
| Communications raising public awareness | 12% | 30% | 16% | 2%* | 15% |
| Community focus/ engagement | 11% | 5% | 5% | 12% | 23% |
| Check Up From the Neck-Up/ Black Dog initiatives | 3% | 10% | - | - | 8% |
| Establishment/ encouragement of peer networks | 8% | - | 16% | 6% | 15% |
| Living Well promotion/ program | 8% | - | - | 16%* | - |
| R U OK? | 3% | 10% | - | 2% | - |

Some examples of verbatim comments provided by respondents include:

*"All work has to now take into account the impact of the NDIS. I do not think this has happened effectively."* [A person with lived experience of mental illness]

*"Television advertisements and education."* [A person with lived experience of mental illness]

*"The Strategy has been a great guide to bringing services into communities and is a model for other jurisdictions."* [Other professional]

*"Check-Up from the Neck-Up is a great education initiative. I believe this should be rolled out more widely by the Commission."* [A person with lived experience of mental illness]

*"The best initiative has been the Commission's support of lived experience and the peer workforce."* [Other professional]

*"The Living Well document was an impressive, innovative piece of research."* [Health professional]

*"The only one that comes to mind would be R U OK? Day, but I'm not sure who originated the idea."* [A person with lived experience of mental illness]

The three Aboriginal respondents each mentioned different topics, as listed in Table 37.

Table 37: Top three research, innovation, policy development, or education initiatives, by Aboriginal and Torres Strait Islander origin

| Topics | Aboriginal n= 3 | Not Aboriginal 99 |
|---|---|---|
| Community focus/ engagement | - | 11% |
| Negative comments on impacts | 33% | 26% |
| Other | - | 7% |
| Check Up From the Neck-Up/ Black Dog initiatives | 33% | 2% |
| Communications raising public awareness | - | 12% |
| Establishment/ encouragement of peer networks | - | 8% |
| Living Well promotion/ program | - | 8% |
| Collaboration/ consultation - NGO's, private providers, etc. | 33% | 3% |

Some examples of verbatim comments provided by respondents include:

ABORIGINAL AND TORRES STRAIT ISLANDERS:

*"Limited availability of service providers. Significant costs to those with mental health conditions, including medication, therapy and support services."* [A family member or carer of a person with mental illness]

*"Check-Up from the Neck-Up is a great education initiative. I believe this should be rolled out more widely by the Commission. Insights in Recovery is also a strong initiative."* [A person with lived experience of mental illness]

*"Research, innovation, policy development and education initiatives are good IF mental health units/workers/ facilities, etc. follow through with all the above."* [A family member or carer of a person with mental illness]

A third of respondents born overseas, who spoke a language other than English at home, could also see few impacts from the Commission's work (33%, compared to 24%-26% of other CALD groups). They were, however, quite often impressed with the public awareness

communications (17%, compared with 0%-13% of other CALD groups). A quarter of respondents born overseas, who spoke English at home, praised the Commission's community engagement activities (24%, compared with 0%-17% of other CALD groups), but also quite often mentioned a reduction in the stigma associated with mental illness, which "allows individuals to disclose lived experiences, and this makes others feel that they are not alone" (12%, compared with 0%-8% of other CALD groups).

Table 38: Top three research, innovation, policy development, or education initiatives, by culturally and linguistically diverse categories

| Topics n= | Born in Australia, speaks English at home 69 | Born in Australia, speaks language other than English at home 4 | Born overseas, speaks English at home 17 | Born overseas, speaks language other than English at home 12 |
|---|---|---|---|---|
| Negative comments on impacts | 26% | 25% | 24% | 33% |
| Communications raising public awareness | 13% | - | 6% | 17% |
| Establishment/ encouragement of peer networks | 9% | 25% | 6% | - |
| Living Well promotion/ program | 9% | - | 6% | 8% |
| Other | 9% | - | - | 8% |
| Community focus/ engagement | 7% | - | 24% | 17% |
| Removal/ reduction of stigma | 3% | - | 12% | 8% |
| Suicide Prevention and Support | 1% | 25% | - | - |
| Seclusion and restraint | 1% | 25% | 6% | - |

Some examples of verbatim comments provided by respondents include:

BORN IN AUSTRALIA, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

> *"I do not think there has been sufficient research, innovation or policy development. If there was, surely some of the emergency services (both paid and volunteers) would have been involved."* [A person with lived experience of mental illness]

*"Peer workers role promoted."* [Health professional]

*"Raising awareness of suicide, narcotic issues."* [Member of the public (none of the above)]

*"The Seclusion review, but it's early days yet."* [Health professional]

BORN OVERSEAS, SPEAKS ENGLISH AT HOME:

*"It is not widely known, therefore very little."* [A family member or carer of a person with mental illness]

*"The new Hunter Collective collaborative projects."* [Health professional]

*"Suicide prevention, the impact of which is yet to be seen, but it has probably started to address the stigma."* [A family member or carer of a person with mental illness]

BORN OVERSEAS, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

*"There is a gap with certain population groups who still have low mental health literacy, such as CALD, new and emerging communities and refugees."* [A person with lived experience of mental illness]

*"Education initiatives, like they were at the Easter Show. Their reports can have a positive impact on the sector at driving change."* [A person with lived experience of mental illness]

*"Policy development: it's crucial to implement a good policy for consumers and carers. Any policy can have a good or bad outcome to these vulnerable groups. Advocacy is a way to support these people who are sometimes facing very difficult circumstances and unfair treatment."* [A family member or carer of a person with mental illness]

Table 39: Top three research, innovation, policy development, or education initiatives, overall and by remoteness category

| Topics | n= | Overall<br>184 | Major cities<br>124 | Inner regional<br>33 | Outer regional / remote<br>5 |
|---|---|---|---|---|---|
| Negative comments on impacts | | 20% | 19% | 18% | 40% |
| Community focus/ engagement | | 15% | 14% | 18% | - |
| Communications raising public awareness | | 11% | 14% | 12% | - |
| Youth/ young adult focus | | 4% | 4% | 3% | 20% |

| Topics | n= | Overall<br>184 | Major cities<br>124 | Inner regional<br>33 | Outer regional / remote<br>5 |
|---|---|---|---|---|---|
| R U OK? | | 2% | 2% | - | 20% |
| MH First Aid training/ courses | | 1% | 0%* | 3% | 20% |

Some examples of verbatim comments provided by respondents include:

MAJOR CITIES:

*"Negligible. Good intentions, but poor execution."* [Health professional]

*"There has been no impact on the mental health sector. There is no appetite for change. If deaths in inpatient settings can't effect change, what on earth will? A culture of 'no blame', ' also means no accountability."* [Health professional]

*"The MHC has [put] more focus on community support and advocacy for increased funding for mental health services, including prevention and early recovery."* [A person with lived experience of mental illness]

*"The availability of the Strategic Plan brochure online, which uses images and basic explanations of the Plan. This makes the Plan accessible to all, as sometimes it is difficult to read large documents when unwell. This ensures consumers know what their rights are and how their treatment should be."* [A person with lived experience of mental illness]

INNER REGIONAL:

*"Their website says they do [have an impact], but none of it seems to make any difference to the way individuals and families are treated and the lack of stable funding so workers and programs stay available."* [A person with lived experience of mental illness]

*"Carer and Consumer participatory projects."* [Health professional]

*"I have seen their education initiatives … the television ads. However, they all seemed to be aimed at very young people, who feel life isn't going their way, so they get depressed and talk of suicide."* [A family member or carer of a person with mental illness]

OUTER REGIONAL/REMOTE:

*"I can't think of any I would attach specifically to the Commission; it's pretty invisible."* [Health professional]

*"R U OK?"* [Health professional]

*"Mental health first aid training is basically beneficial, but it can lead to false confidence in dealing with complex issues."* [Health professional]

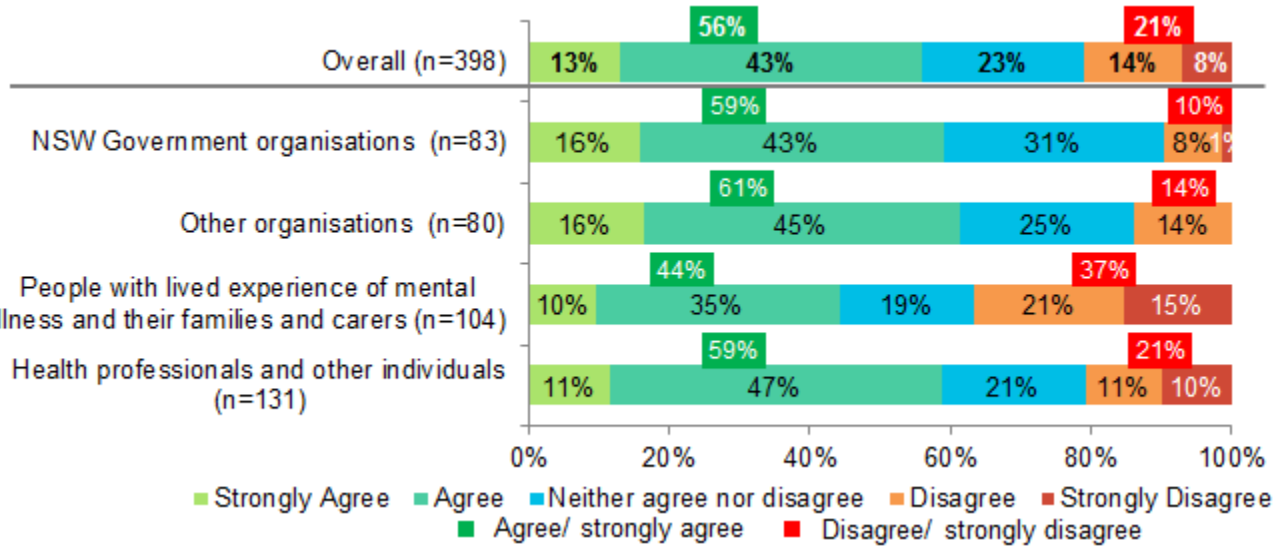
# 5.5 Education

The Mental Health Commission's eighth function, under the Act, was to *educate the community about mental health issues, including for the purpose of reducing the stigma associated with mental illness and discrimination against people who have a mental illness*.

## 5.5.1 Education initiatives

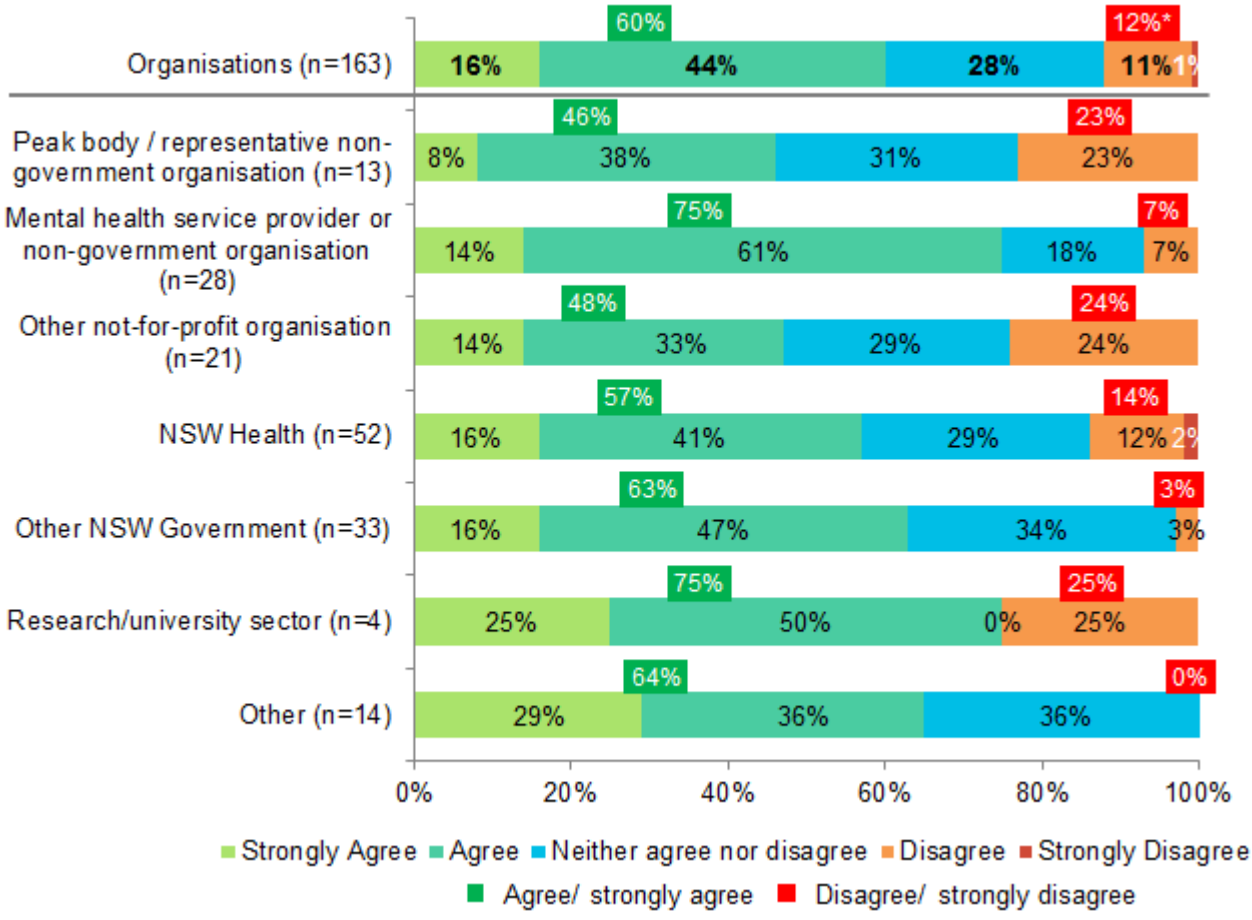
Respondents were asked whether they agreed or disagreed that the Mental Health Commission had effectively undertaken initiatives to educate the community about mental health issues (including to reduce the stigma and discrimination). Over half agreed/ strongly agreed that it had (56%). Levels of agreement were similar across the major segments shown in Figure 65, with the exception that people with lived experience and carers were less positive (44%) regarding the Commission's work in educating the community.

Figure 53: Level of agreement that the Commission effectively undertook *initiatives to educate the community about mental health issues*, overall and by high level organisation and individual groupings (n=398)



Compared to the overall sample, a marginally higher proportion of organisations agreed/ strongly agreed that the Commission's education initiatives had been effective (60% of organisations), and significantly fewer organisations disagreed/ strongly disagreed (12%, compared with 21% overall). Three-quarters of mental health providers or non-government organisations and of research/ university sector respondents (three of the four) agreed/ strongly agreed, but the difference was not statistically significant (75% of both organisation types). (See Figure 54.)

Figure 54: Organisations' level of agreement that the Commission effectively undertook *initiatives to educate the community about mental health issues*, overall and by organisation type (n=163)



While half of the individuals agreed/ strongly agreed that the Commission had effectively undertaken initiatives to educate the community (52%), respondents with a lived experience of mental illness were less convinced; half disagreed/ strongly disagreed (52%) and only a third agreed/ strongly agreed (33%).

A higher percentage of Non-Aboriginal respondents than Aboriginal respondents agreed/ strongly agreed with the effectiveness of the Commission's education initiatives, but the difference was not statistically significant (53% and 45% respectively).

Figure 55 and Figure 56 show the agreement levels for individuals by backgrounds and Aboriginality.

Figure 55: Individuals' level of agreement that the Commission effectively undertook *initiatives to educate the community about mental health issues*, overall and by individual background (n=235)

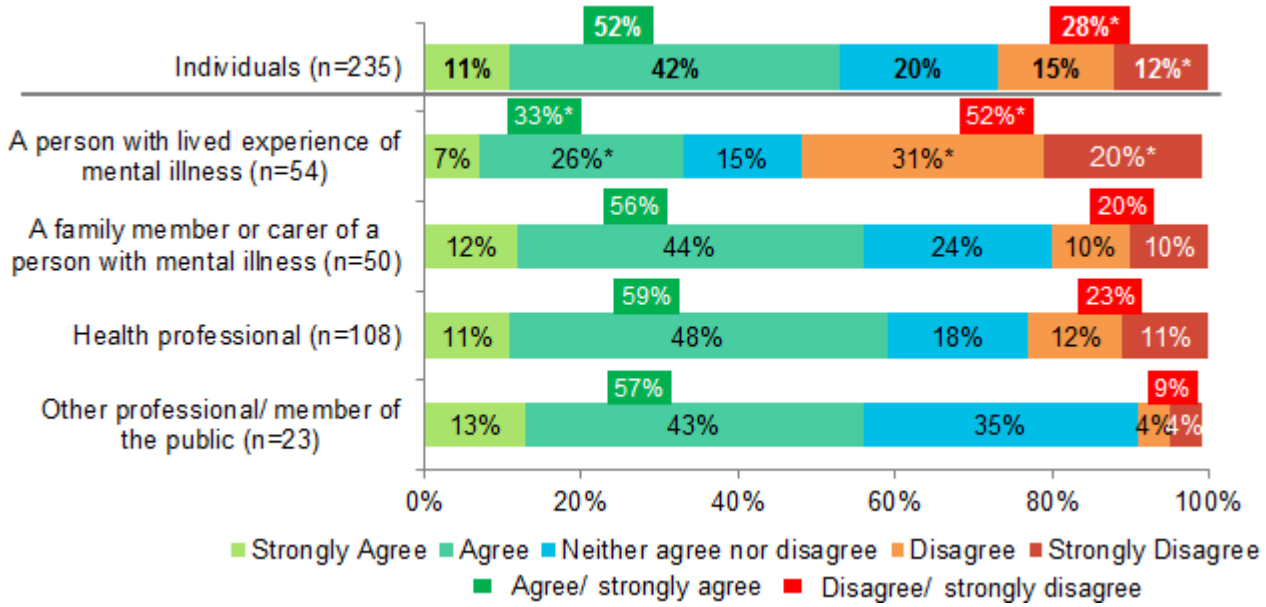
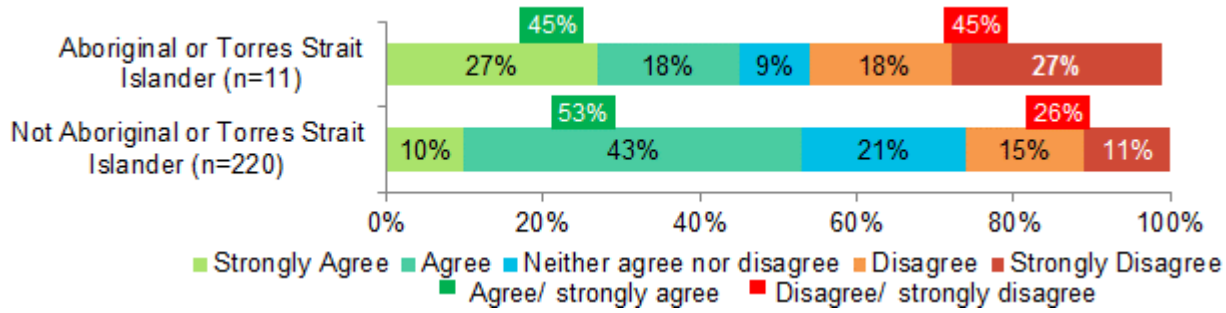
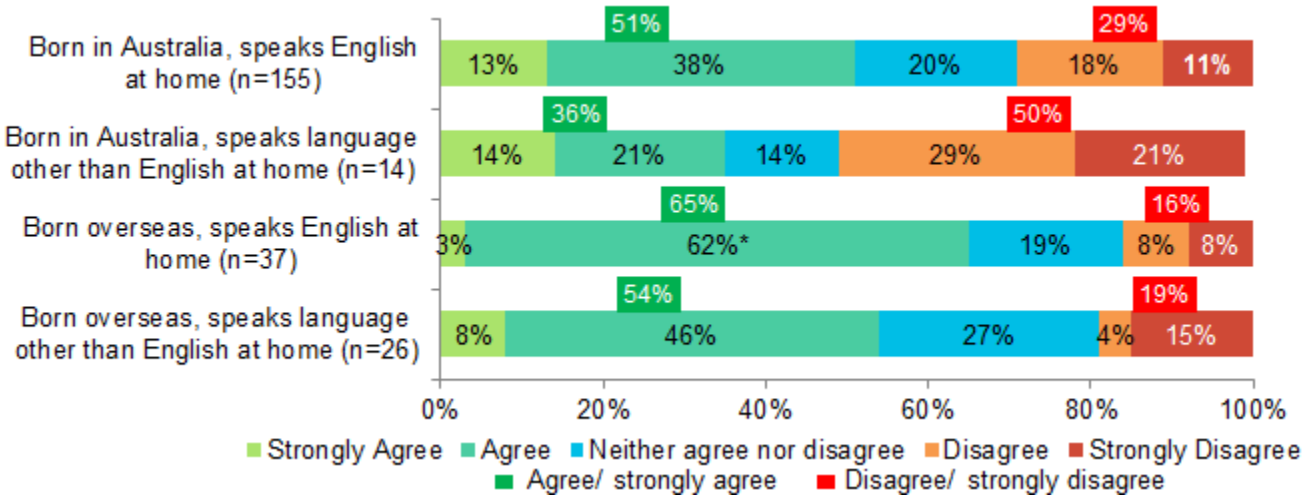



Figure 56: Level of agreement that the Commission effectively undertook *initiatives to educate the community about mental health issues*, by Aboriginal and Torres Strait Islander origin (n=231)



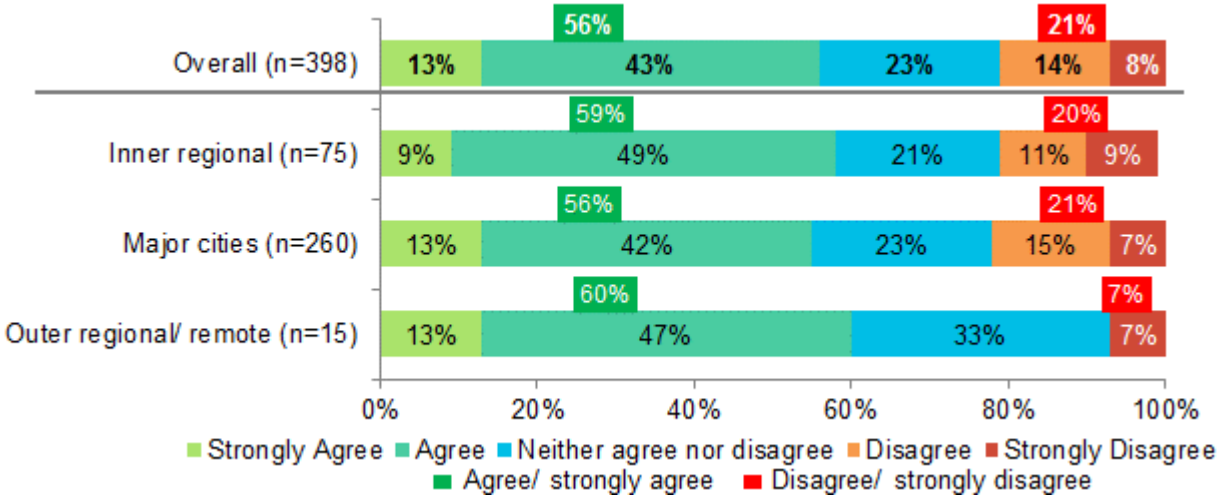
The most significant difference in the responses from CALD segments lay in the proportion of respondents who were born overseas and spoke English at home who agreed that the Commission had effectively undertaken education initiatives. This segment had the highest percentage agreeing (62%, compared with 21%-46% of other CALD segments), as well as the highest agreeing/ strongly agreeing (65%, compared with 36%-54%).

Figure 57: Level of agreement that the Commission effectively undertook *initiatives to educate the community about mental health issues*, by culturally and linguistically diverse categories (n=232)




The agreement levels from each of the remoteness categories were similar, with a very small increase in the proportion of respondents who agreed/ strongly agreed as remoteness increased (56% of those in major cities, to 59% in inner regional areas, to 60% in outer regional/ remote areas). (See Figure 58.)

Figure 58: Level of agreement that the Commission effectively undertook *initiatives to educate the community about mental health issues*, overall and by remoteness category (n=398)



### 5.5.2 The impact of the Mental Health Commission's education initiatives

As listed in Table 34 to Table 38, on pages 104 to 111, 11% of respondents mentioned the Commission's public awareness campaigns as examples of education initiatives which had a positive impact on the mental health and wellbeing of the people of New South Wales. A couple of the initiatives mentioned which could be considered education initiatives, or to have an educational component, included:

- Check up from the Neck-up (when taken out into the community)
- R U OK?
- Project Air Strategy for Schools

One of the greatest outcomes of education initiatives was seen to be the reduction of mental illness stigma in society, which was mentioned by 4% of respondents.

## 5.6 Advocacy

The Act included two advocacy and promotion functions for the Mental Health Commission (the sixth and seventh functions). These were to *advocate for and promote*:

- *the prevention of mental illness and early intervention strategies for mental health*
- *the general health and well-being of people who have a mental illness and their families and carers*.

### 5.6.1 Advocacy and promotion functions

Respondents thought that the Commission had done a better job at advocating and promoting the general health and wellbeing of people with a mental illness and their families (53% agreed/ strongly agreed), than at advocating and promoting the prevention of mental illness and early intervention strategies (43% agreed/ strongly agreed).

A familiar pattern of results emerged across both statements, with higher levels of agreement among NSW Government and other organisations, than among individuals with lived experience/carers; and those of health professionals/other individuals falling somewhere between the two.

Figure 59: Level of agreement that the Commission effectively fulfilled its functions to advocate for and promote *the prevention of mental illness and early intervention strategies for mental health*, overall and by high level organisation and individual groupings (n=390)

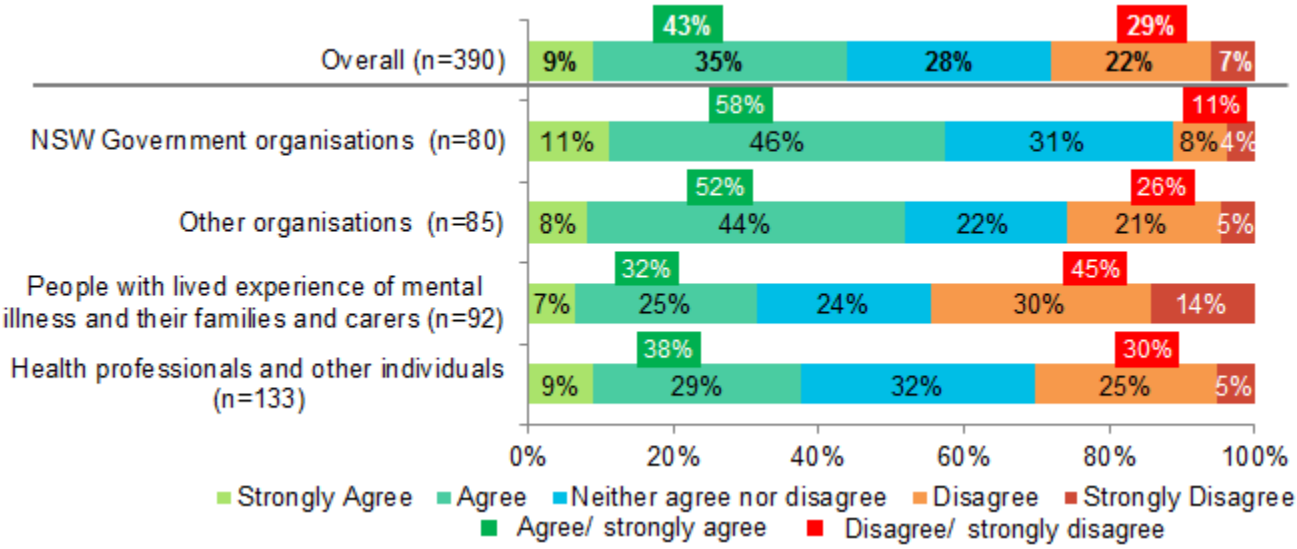
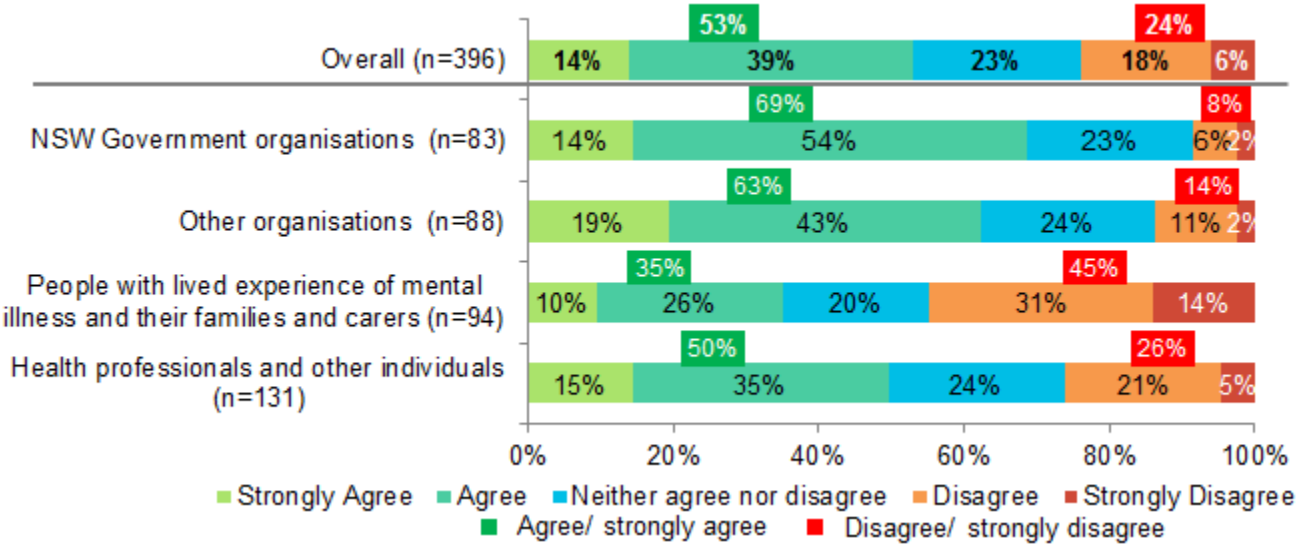



Figure 60: Level of agreement that the Commission effectively fulfilled its functions to advocate for and promote *the general health and wellbeing of people who have a mental illness and their families*, overall and by high level organisation and individual groupings (n=396)



As usual, organisations were more positive about the Commission's advocacy and promotion efforts than individuals, with 55% agreeing/ strongly agreeing for *general health and wellbeing*, and 65% for *prevention and early intervention*. Any variations between organisation types were not statistically significant, as shown in Figure 61 and Figure 62.

Figure 61: Organisations' level of agreement that the Commission effectively fulfilled its functions to advocate for and promote t*he prevention of mental illness and early intervention strategies for mental health*, overall and by organisation type (n=165)

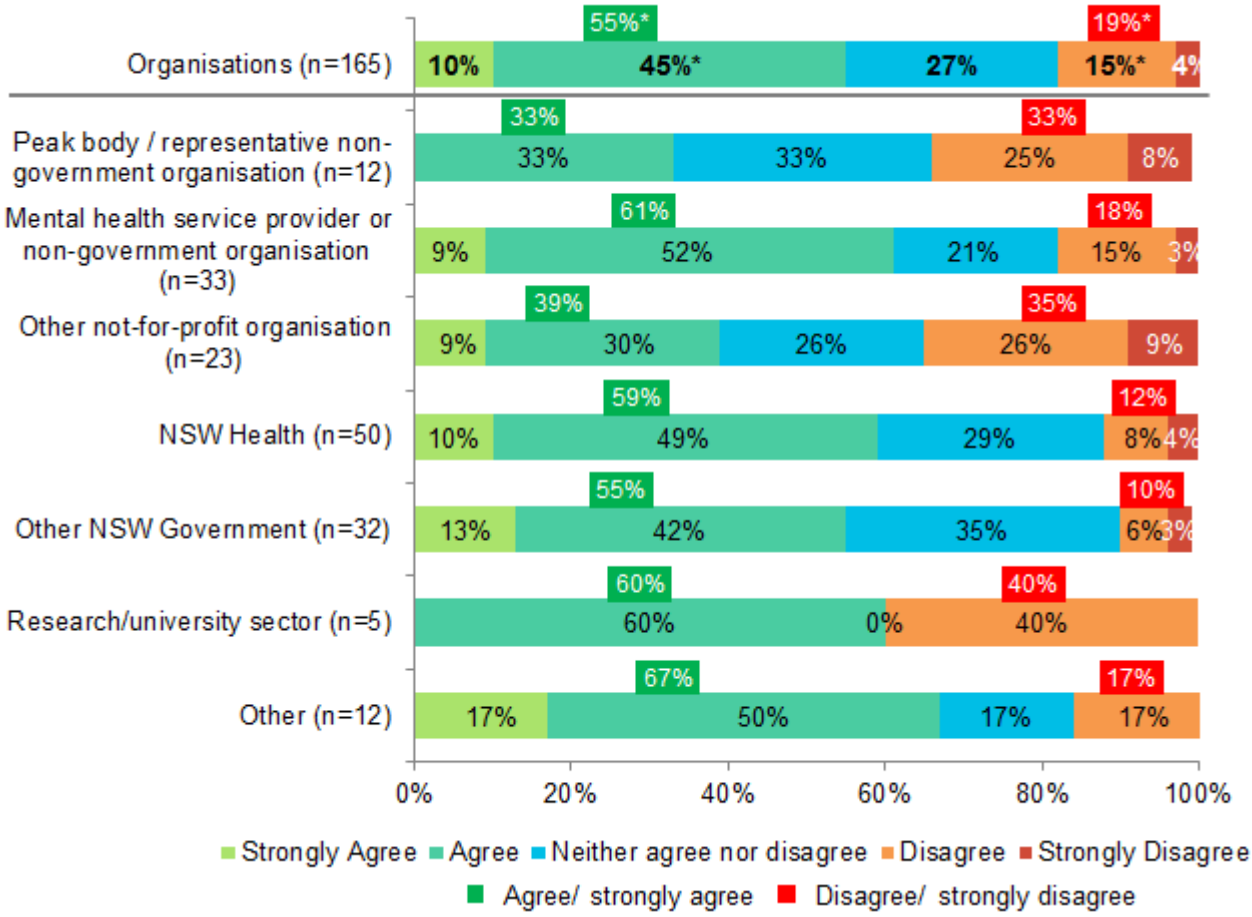
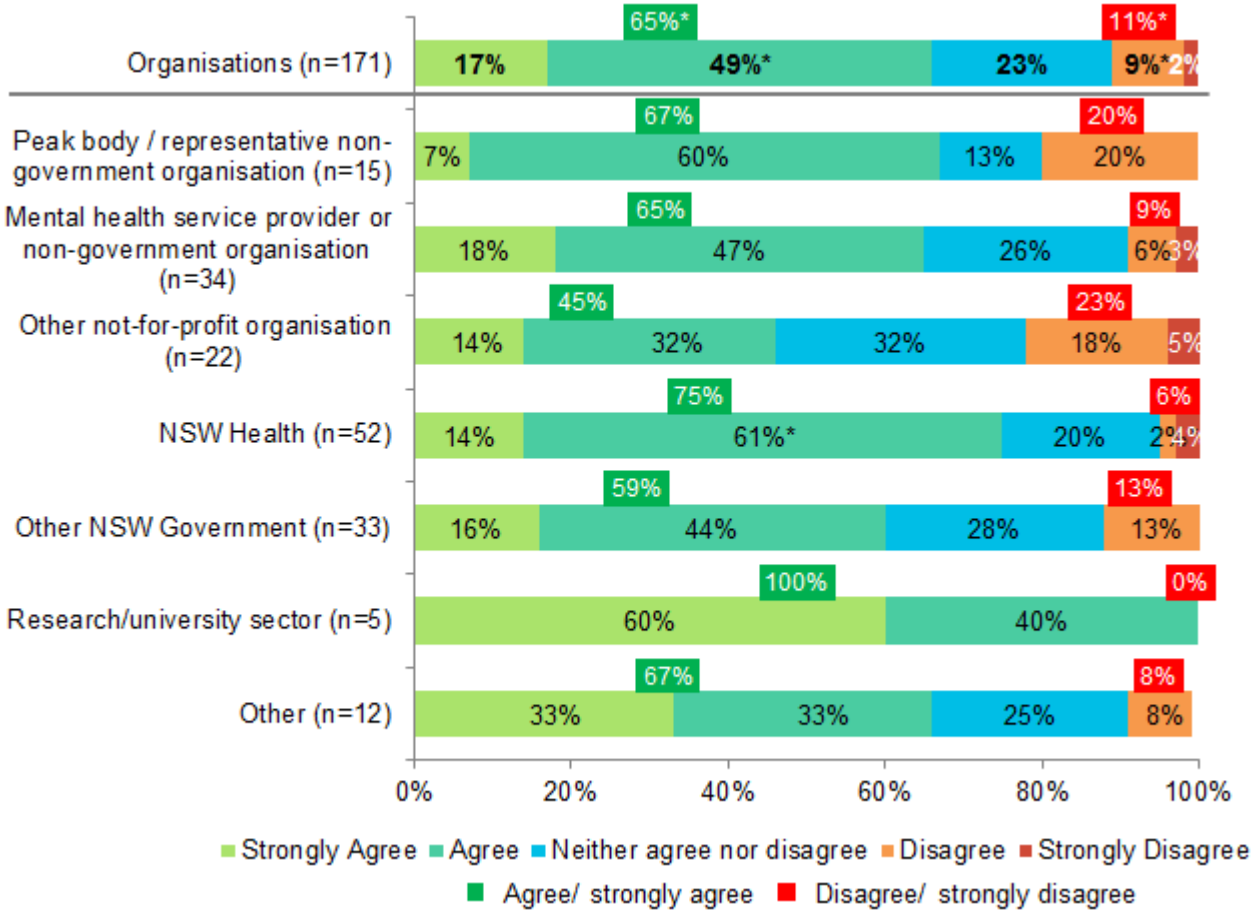


Figure 62: Organisations' level of agreement that the Commission effectively fulfilled its functions to advocate for and promote *the general health and wellbeing of people who have a mental illness and their families*, overall and by organisation type (n=171)




While a third of individuals agreed/ strongly agreed that the Commission had effectively advocated and promoted *prevention and early intervention* (35%), 44% were positive about it having effectively advocated and promoted *general health and wellbeing*. (See Figure 63 and Figure 64.) People with a lived experience of mental illness thought least highly of the Commission's advocacy and promotion work, with only a fifth agreeing/ strongly agreeing about *prevention and early intervention* (21%), and 29% agreeing/ strongly agreeing about *general health and wellbeing*.

Figure 63: Individuals' level of agreement that the Commission effectively fulfilled its functions to advocate for and promote *the prevention of mental illness and early intervention strategies for mental health*, overall and by individual background (n=225)

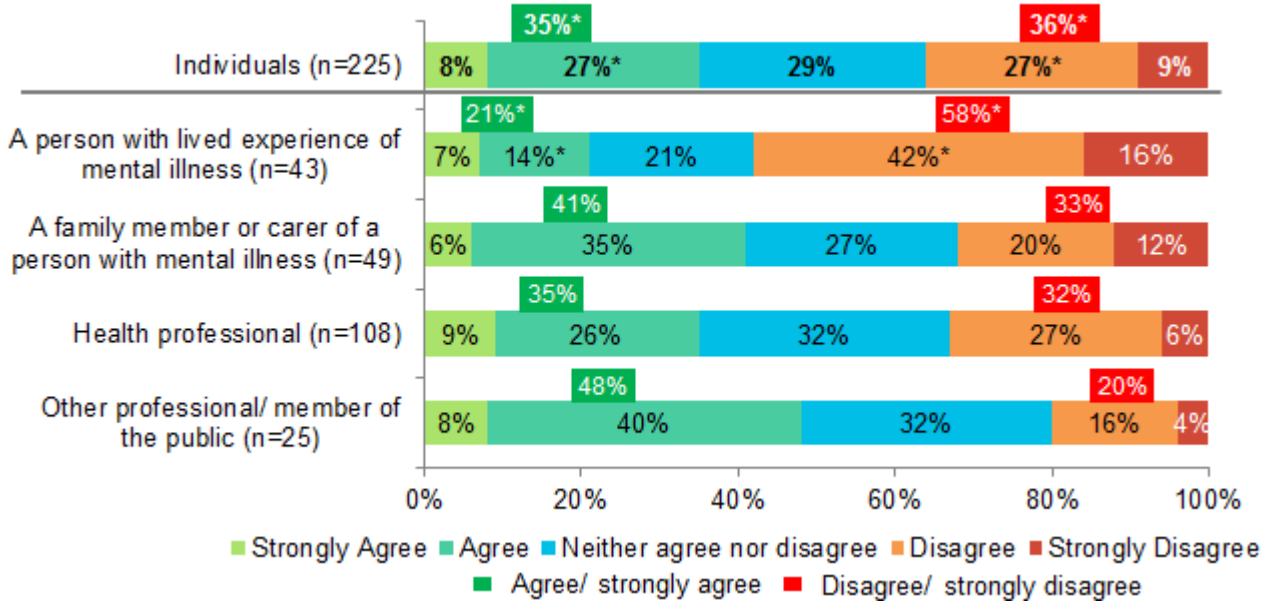



Figure 64: Individuals' level of agreement that the Commission effectively fulfilled its functions to advocate for and promote *the general health and wellbeing of people who have a mental illness and their families*, overall and by individual background (n=225)

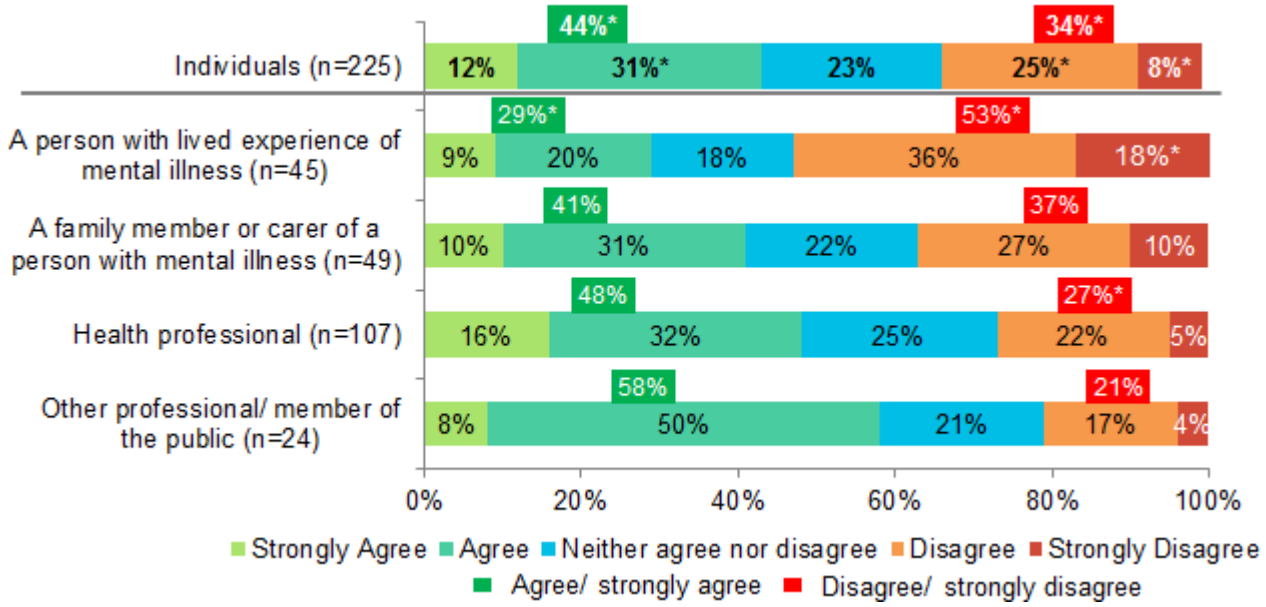


Figure 65 and Figure 66 show that there were no significant differences by Aboriginality; although Aboriginal respondents viewed the Commission's *general health and wellbeing* advocacy and promotion efforts more favourably than their counterparts (55%, compared with 44% of non-Aboriginal respondents).

Figure 65: Level of agreement that the Commission effectively fulfilled its functions to advocate for and promote t*he prevention of mental illness and early intervention strategies for mental health*, by Aboriginal and Torres Strait Islander origin (n=221)

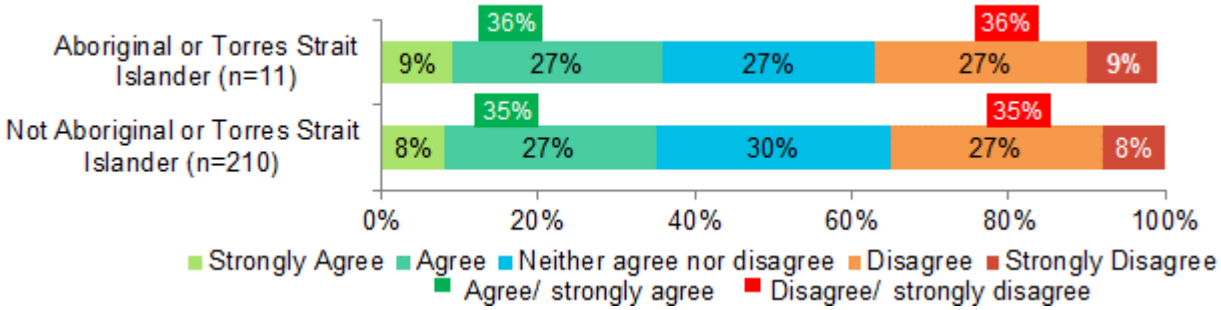
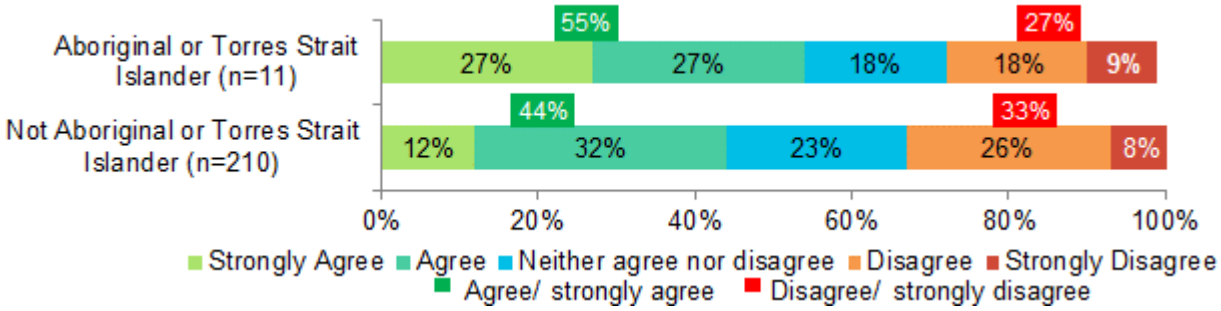



Figure 66: Level of agreement that the Commission effectively fulfilled its functions to advocate for and promote *the general health and wellbeing of people who have a mental illness and their families*, by Aboriginal and Torres Strait Islander origin (n=221)



The only significant finding for CALD groups was that those born overseas, who spoke English at home, most often agreed that *prevention and early intervention* had been effectively advocated for and promoted (41%, compared with 20%-31% for other CALD segments). (See Figure 67 and Figure 68.)

Figure 67: Level of agreement that the Commission effectively fulfilled its functions to advocate for and promote *the prevention of mental illness and early intervention strategies for mental health*, by culturally and linguistically diverse categories (n=221)

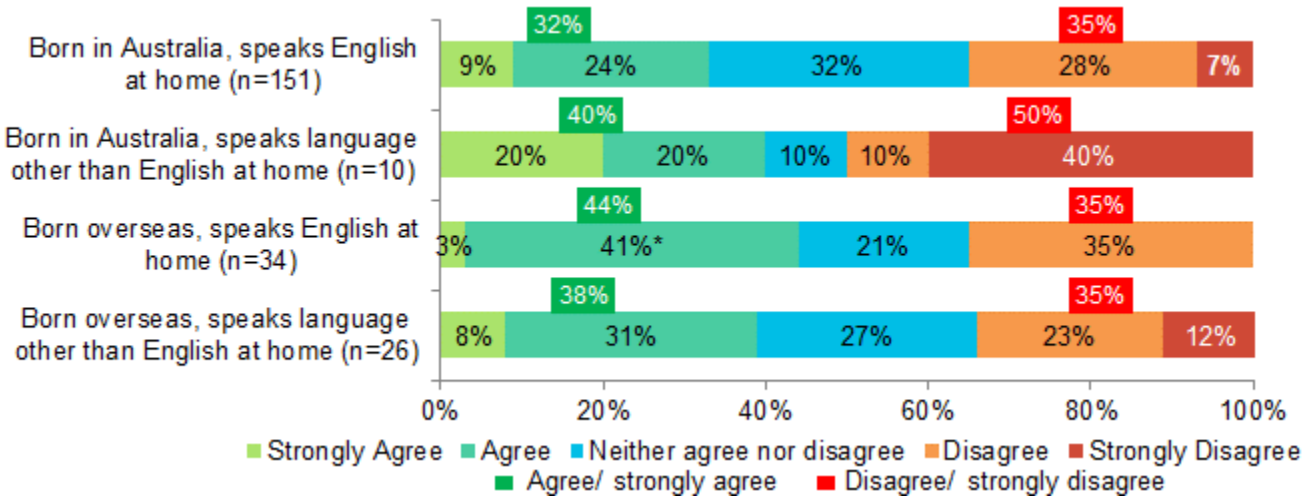
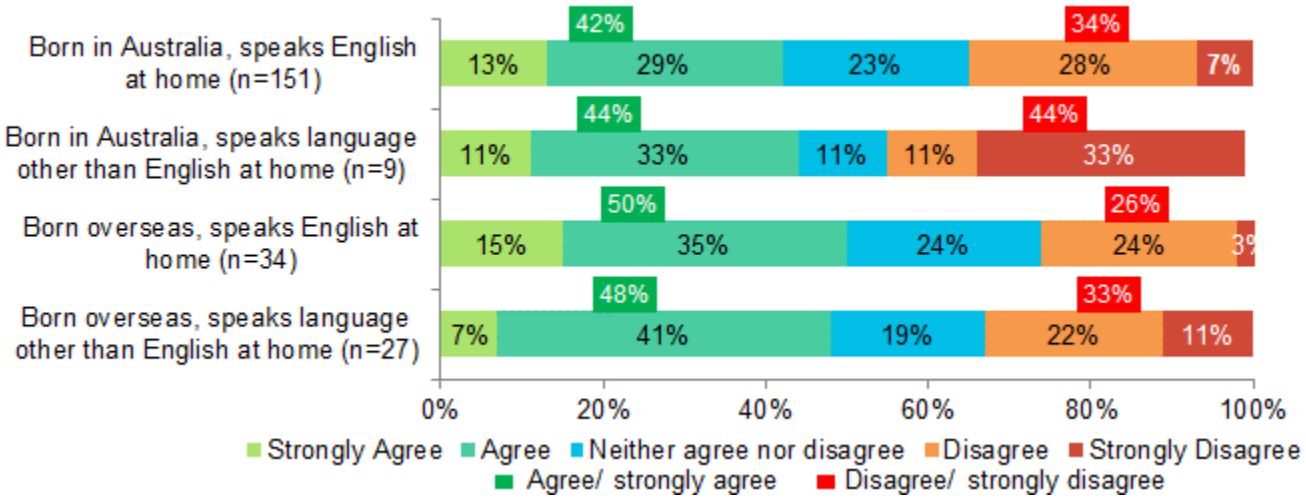



Figure 68: Level of agreement that the Commission effectively fulfilled its functions to advocate for and promote *the general health and wellbeing of people who have a mental illness and their families*, by culturally and linguistically diverse categories (n=221)



Outer regional/ remote respondents had the lowest rate of agree/ strongly agree of the remoteness categories, for both questions, but the differences were not statistically significant (44% for *general health and wellbeing*, 25% for *prevention and early intervention*, compared with 53%-55% and 40%-46% for other remoteness categories, respectively). (Refer to Figure 69 and Figure 70.)

Figure 69: Level of agreement that the Commission effectively fulfilled its functions to advocate for and promote *the prevention of mental illness and early intervention strategies for mental health*, overall and by remoteness category (n=390)

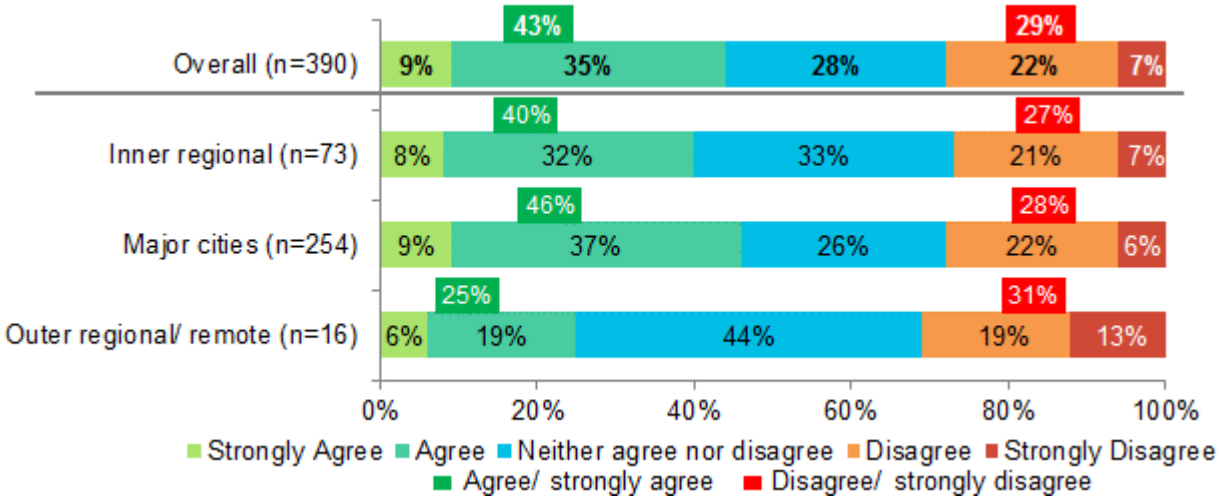
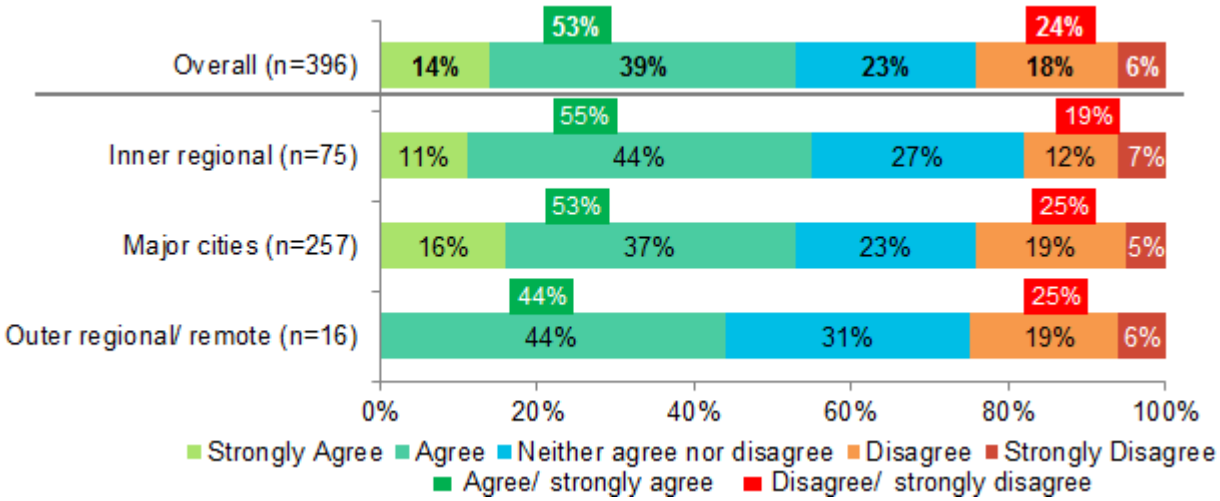



Figure 70: Level of agreement that the Commission effectively fulfilled its functions to advocate for and promote *the general health and wellbeing of people who have a mental illness and their families*, overall and by remoteness category (n=396)



## 5.6.2 The impacts of the Mental Health Commission's advocacy and promotion activities

If respondents had rated either of the previous questions about the Commission having effectively fulfilled its functions to advocate and promote the prevention of mental illness and early intervention strategies, and general health and wellbeing, they were asked what impact these advocacy and promotion activities had had on the mental health sector or the mental health and wellbeing of the people of New South Wales.

A third of respondents thought that the Commission's advocacy and promotion activities had resulted in greater awareness and understanding of mental illness in the general community (31%). However, 28% thought there was little evidence of any impact, or said that they had not noticed any advocacy or promotion activities, and 12% took the opportunity to voice concerns about the mental health sector in general, or the Commission's or Government's role and limited impact beyond advocacy and promotion activities.

Submissions from NSW Government were markedly more likely than the other segments to express that the Commission's promotion activities had resulted in greater awareness of mental illness (60%, compared with only 18% of individuals with lived experience or their carers). The latter were correspondingly more likely, along with the other individuals and health professionals, to articulate negative response to this question.

Table 40: Top three impacts of advocacy and promotion activities, overall and by high level organisation and individual groupings

| Topics | n= | Overall 40 | NSW Government organisations 49 | Other organisations 49 | People with lived experience of mental illness and their families and carers 61 | Health professionals and other individuals 40 |
|---|---|---|---|---|---|---|
| Greater awareness/ promotion/ understanding | | 31% | 60% | 45% | 18% | 11% |
| Little/ no evidence/ negative perceptions | | 28% | 13% | 16% | 41% | 38% |
| Other/ broader concerns about MHC | | 12% | 8% | 4% | 18% | 16% |
| General positive | | 9% | 13% | 8% | 4% | 10% |

| Topics | n= | Overall 40 | NSW Government organisations 49 | Other organisations 49 | People with lived experience of mental illness and their families and carers 61 | Health professionals and other individuals 40 |
|---|---|---|---|---|---|---|
| Seen some progress/ too early to say/ need more time to evaluate | | 7% | 3% | 14% | 6% | 5% |
| Reduction of stigma | | 9% | 5% | 14% | 10% | 7% |

Organisations were far more positive than individuals about the increased levels of awareness and understanding about mental illness in the general population, with half commenting on this achievement overall (52%), and 62% of 'other' NSW Government respondents mentioning it. Organisations overall were also significantly less likely to say that the Commission's advocacy and promotion activities had caused minimal, or limited impact (15%), although a third of peak bodies/ representative non-government organisations did say this (33%), or that it was too early to determine outcomes from the Commission's work (33%).

Table 41: Top three impacts of advocacy and promotion activities mentioned by organisations, overall and by organisation types

| Topics | n= | Organisations overall 89 | Peak body / representative non-government orgs 9 | Mental health service provider or non-gov org 14 | NSW Health 27 | Other NSW Government 13 | Research/university sector 4 | Other not-for-profit org 15 | Other 7 |
|---|---|---|---|---|---|---|---|---|---|
| Greater awareness/ promotion/ understanding | | 52%* | 11% | 50% | 59% | 62% | 50% | 47% | 71% |

| Topics n= | Organisations overall 89 | Peak body / representative non-government orgs 9 | Mental health service provider or non-gov org 14 | NSW Health 27 | Other NSW Government 13 | Research/university sector 4 | Other not-for-profit org 15 | Other 7 |
|---|---|---|---|---|---|---|---|---|
| Little/ no evidence/ negative perceptions | 15%* | 33% | 14% | 19% | - | - | 13% | 14% |
| Reduction of stigma | 10% | 11% | 14% | - | 15% | - | 20% | 14% |
| General positive | 10% | 11% | 7% | 7% | 23% | - | 13% | - |
| Seen some progress/ too early to say/ need more time to evaluate | 9% | 33% | 14% | - | 8% | - | 13% | - |
| Other/ broader concerns about MHC | 6%* | - | 7% | 11% | - | - | - | 14% |
| Engagement with consumers/ lived experience/ treatment focussed | 9% | 11% | 21% | 7% | 8% | 25% | - | - |

Some examples of verbatim comments provided by respondents include:

*"Raising the level of awareness and giving people a voice."* [NSW Health]

*"There needs to be a stronger action plan. Too many people just slip through the gap."* [Other not-for-profit organisation]

*"Advocating, yes. Getting the services to the population - not so much."* [NSW Health]

*"Improved awareness; reduction in stigma."* [Mental health service provider or non-government organisation]

*"Overall, a significant contribution."* [Peak body / representative non-government organisation]

*"Highlighted shortfalls in mental health services, whilst promoting pathway options for improvement."* [Other NSW Government]

*"Empowered people to talk about mental illness and asking for help, but more needs to be done to reduce the stigma associated with mental health. Employers*

*are reluctant to hire people that openly admit to having had or currently have a mental illness."* [Other not-for-profit organisation]

*"It has resulted in a lot of lip service from governments on the importance of mental health funding, but this emphasis seems to have waned somewhat."* [NSW Health]

*"The encouragement of individuals to tell their stories, both good and bad, has empowered many consumers and carers."* [Mental health service provider or non-government organisation]

*"Providing consumer advocacy panels and meetings."* [NSW Health]

Thirty nine percent of individuals saw little or no evidence of any impacts (39%), and over half of respondents with a lived experience of mental illness (56%), and 42% of health professionals made a comment to this effect. More than a third of 'other' professionals/ members of the public made a non-specific comment about the Commission's advocacy and promotion efforts being "positive", or having a "good impact" (36%).

Table 42: Top three impacts of advocacy and promotion activities mentioned by individuals, overall and by individual background

| Topics | n= | Individuals overall | A person with lived experience of mental illness | A family member or carer of a person with mental illness | Health professional | Other professional/ member of the public |
|---|---|---|---|---|---|---|
| | | 110 | 25 | 24 | 50 | 11 |
| Little/ no evidence/ negative perceptions | | 39%* | 56% | 25% | 42% | 18% |
| Other/ broader concerns about MHC | | 17%* | 12% | 25% | 20% | - |
| Greater awareness/ promotion/ understanding | | 15%* | 16% | 21% | 8% | 27% |
| Seen some progress/ too early to say/ need more time to evaluate | | 5% | 12% | - | 4% | 9% |
| General positive | | 7% | 4% | 4% | 4% | 36% |

Some examples of verbatim comments provided by respondents include:

*"Very little actual impact."* [Health professional]

*"None that I have noticed."* [A family member or carer of a person with mental illness]

*"It is not possible to speak to all NSW. Mental health reform has a very long way to go. I believe the MHC could take credit for pockets of change. No matter how great the MHC's efforts and the commitment of its staff and committees, real change requires genuine heartfelt government commitment."* [A family member or carer of a person with mental illness]

*"Widespread information to dispel myths about mental health makes it a bit easier to seek support from providers of a service. At my workplace, they are finally developing a mental health toolkit and will start training next year."* [A person with lived experience of mental illness]

*"The information promotions activities have helped in raising awareness, but the very limited resources at the front line of the tertiary mental health services remain woefully inadequate to implement all recommendations."* [Health professional]

*"It has started to shift things. [However], the mental health system is deeply entrenched in a risk-averse, punitive way of dealing with consumers, so it will take some work to shift that."* [Health professional]

*"Without the power and influence of the Mental Health Commission, I would hate to think where mental health would be in NSW."* [A family member or carer of a person with mental illness]

Four out of five Aboriginal respondents made reference to there having been no tangible impacts (80%).

Table 43: Top three impacts of advocacy and promotion activities, by Aboriginal and Torres Strait Islander origin

| | Aboriginal | Not Aboriginal |
|---|---|---|
| **Topics** **n=** | **5** | **102** |
| Little/ no evidence/ negative perceptions | 80% | 36% |
| Greater awareness/ promotion/ understanding | 20% | 15% |
| General positive | - | 8% |
| Reduction of stigma | 20% | 8% |
| Other/ broader concerns about MHC | - | 18% |

Some examples of verbatim comments provided by respondents include:

ABORIGINAL AND TORRES STRAIT ISLANDERS:

> *"It has had no effect."* [A person with lived experience of mental illness]
>
> *"It wasn't really supported at all levels. You can promote all you like, but if systems don't change and this isn't supported by government at all levels, nothing changes."* [Health professional]
>
> *"The advocacy of lived experience and carer perspectives at every level has had a positive impact; it reduces stigma & increases knowledge in the wider community. The peer work resource (Peer Work Hub) is also fantastic."* [A person with lived experience of mental illness]

There were no significant deviations in opinions about the impacts (or lack of impacts) from any of the CALD groups, as shown in Table 44.

Table 44: Top three impacts of advocacy and promotion activities, by culturally and linguistically diverse categories

| Topics n= | Born in Australia, speaks English at home 73 | Born in Australia, speaks language other than English at home 5 | Born overseas, speaks English at home 18 | Born overseas, speaks language other than English at home 12 |
|---|---|---|---|---|
| Little/ no evidence/ negative perceptions | 42% | 60% | 28% | 25% |
| Greater awareness/ promotion/ understanding | 18% | - | 11% | 8% |
| Other/ broader concerns about MHC | 15% | - | 28% | 17% |
| Reduction of stigma | 7% | 40% | 11% | - |
| Seen some progress/ too early to say/ need more time to evaluate | 1%* | 20% | 11% | 17% |
| Engagement with consumers/ lived experience/ treatment focussed | 7% | - | 11% | 8% |

Some examples of verbatim comments provided by respondents include:

BORN IN AUSTRALIA, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

*"No real impact … people who seek assistance for mental help problems are usually turned away from hospital facilities because they are full."* [Member of the public (none of the above)]

*"There has been no impact for myself, as I have no idea what they have done or are doing in my local community."* [A person with lived experience of mental illness]

*"Some level of stigma reduction, but more coordinated work with beyondblue and others needs to occur."* [Health professional]

*"I feel as though the impacts have been minimal and still not satisfactory … [However], it is progressing towards reducing stigma and also empowering the people of NSW."* [A person with lived experience of mental illness]

BORN OVERSEAS, SPEAKS ENGLISH AT HOME:

*"No effect. Patients aren't getting the support or care they need."* [A person with lived experience of mental illness]

*"Has duplicated many services, without much attention to the rehabilitation services to provide a better functioning life."* [Health professional]

*"In the last five years, there has been considerable advocacy and awareness of mental illness that has begun to lessen the stigma associated with mental illness. It is much more talked about and with greater understanding. There is still a long way to go, but those caring for people with mental illness are now speaking up and educating others."* [A family member or carer of a person with mental illness]

*"There is still a lot more work to do to make a major impact on awareness and service change."* [Health professional]

*"Advocacy for carers of people who have mental health conditions."* [A family member or carer of a person with mental illness]

BORN OVERSEAS, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

*"No impact on people experiencing mental health issues."* [Health professional]

*"We need more credentialed mental health nurses within the community sector, to provide care for those who fall between the gaps of private and public mental health services."* [Health professional]

*"CALD communities are taking in all the current changes incrementally. It had taken years to learn, understand and navigate the 'old systems' and it is now increasing their stress levels to 're-learn' the new process again because of their level of English language proficiency and coming from a culture where there is no support established where they come from."* [Other professional]

There was little variation between remoteness categories, as shown in Table 45.

Table 45: Top three impacts of advocacy and promotion activities, overall and by remoteness category

| Topics | n= | Overall 199 | Major cities 132 | Inner regional 38 | Outer regional / remote 10 |
|---|---|---|---|---|---|
| Greater awareness/ promotion/ understanding | | 31% | 33% | 24% | - |
| Little/ no evidence/ negative perceptions | | 28% | 27% | 29% | 50% |
| Other/ broader concerns about MHC | | 12% | 11% | 18% | 20% |
| Engagement with consumers/ lived experience/ treatment focussed | | 8% | 6% | 5% | 20% |

Some examples of verbatim comments provided by respondents include:

MAJOR CITIES:

*"Fay Jackson has raised the profile for people with lived experience. Her role modelling is extraordinary."* [Other NSW Government]

*"Mental health advocacy and promotion of trauma informed care is so important and has been embraced by the Commission."* [Mental health service provider or non-government organisation]

*"I don't believe there has been any impact just yet. We have a long way to go in implementing the strategic plan and people still suffer and staff still struggle to be able to implement the action points of the plan."* [Health professional]

*"Little, if any [impact]."* [A family member or carer of a person with mental illness]

*"This question is difficult to answer as there needs to be a formal evaluation of the MH Commission's advocacy and promotion activities!"* [Health professional]

INNER REGIONAL:

*"No effect. Patients aren't getting the support or care they need."* [A person with lived experience of mental illness]

*"Apart from Mental Health Week, there is none."* [Health professional]

*"It has shone more light on the issues and brought them more into focus for the general community."* [NSW Health]

*"Raising awareness is fine, but it only lets consumers down when there isn't the staffing to provide the services advertised."* [Health professional]

OUTER REGIONAL/REMOTE:

*"The mental health sector is barely able to manage the mental health of NSW people. Intervention and support is minimal at best, and regularly has a negative impact on clients. Crisis 'intervention/assistance' has a two week wait time … unacceptable for those in crisis, especially those with suicidal thoughts/ideation. There are many pitfalls yet to be addressed."* [A person with lived experience of mental illness]

*"Not much."* [Health professional]

*"General promotion programs are good, but we need stronger advocacy for reforms to the Mental Health Act in regard to recognition of psychological harm."* [A family member or carer of a person with mental illness]

*"MHC policy documents promote a whole person approach and visits encourage change in services. NSW Health rarely visits."* [Health professional]

# 6 The Ministerial Charter letter of 2016

The Ministerial Charter letter of 2016 identified some priorities for the Mental Health Commission for 2016-17.

The Ministry of Health selected two of these priorities to focus on in the online consultation survey:

- to *continue to work closely with the NSW Government and Commonwealth agencies to ensure the NDIS takes appropriate account of the needs of people with psychosocial disability as a consequence of mental illness*
- to *further develop innovative responses to the mental health and wellbeing needs of young people, noting their particular patterns of distress, service access preferences and help-seeking behaviours*.

Compared with the results for most of the Commission's functions, the overall agreement that the Commission had been effective in meeting these two priorities was low, at a quarter and a third of submissions respectively (26% and 36%). Of the two, the priority focusing on the NDIS did more poorly in respondents' eyes, and even organisations, which tended to be more positive about the Commission, only agreed/ strongly agreed in 30% of their submissions. Individuals with a lived experience of mental illness, in particular, were less likely than other individuals to agree/ strongly agree with the statement about the Commission having effectively ensured that the NDIS take appropriate account of the needs of people with psychosocial disability as a consequence of mental illness (11%).

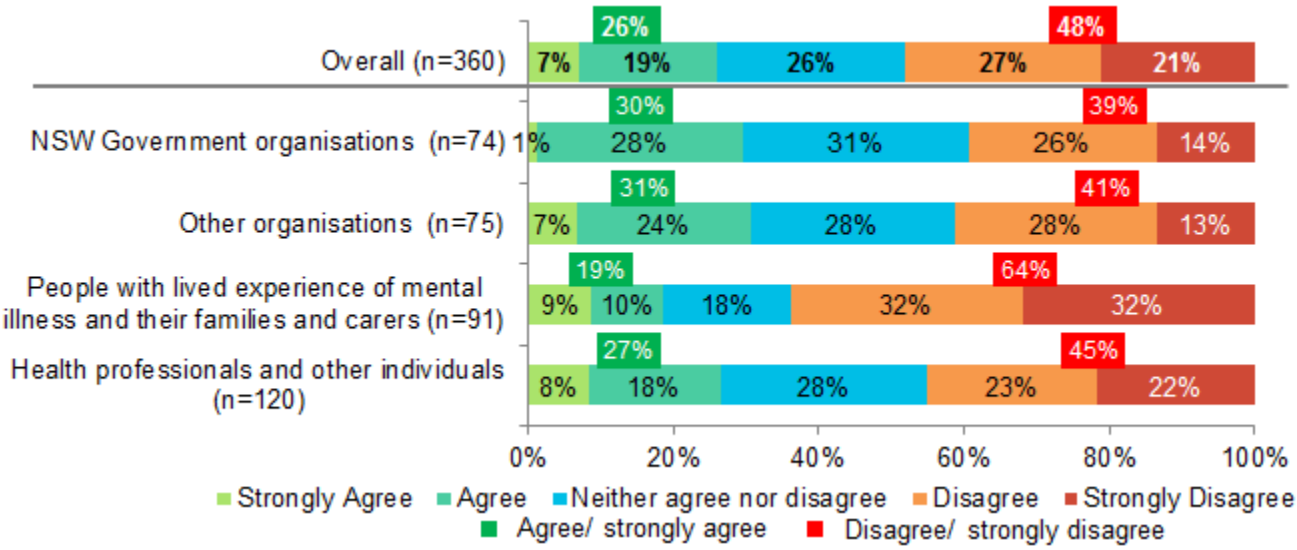
Unfortunately, young people did not provide their views on the Commission's responses to their particular needs; however, health professionals gave this area of the Commission's work an uncharacteristically low rating.

# 6.1 Charter letter priority: the NDIS

A specific question was asked as part of the consultation about whether respondents believed that the Commission had effectively ensured that the NDIS takes account of the needs of people with a psychosocial disability as a consequence of mental illness. Only a quarter (26%) of submissions indicated broad agreement, with almost a half (48%) broadly disagreeing with this premise. The remaining quarter (26%) were neutral.

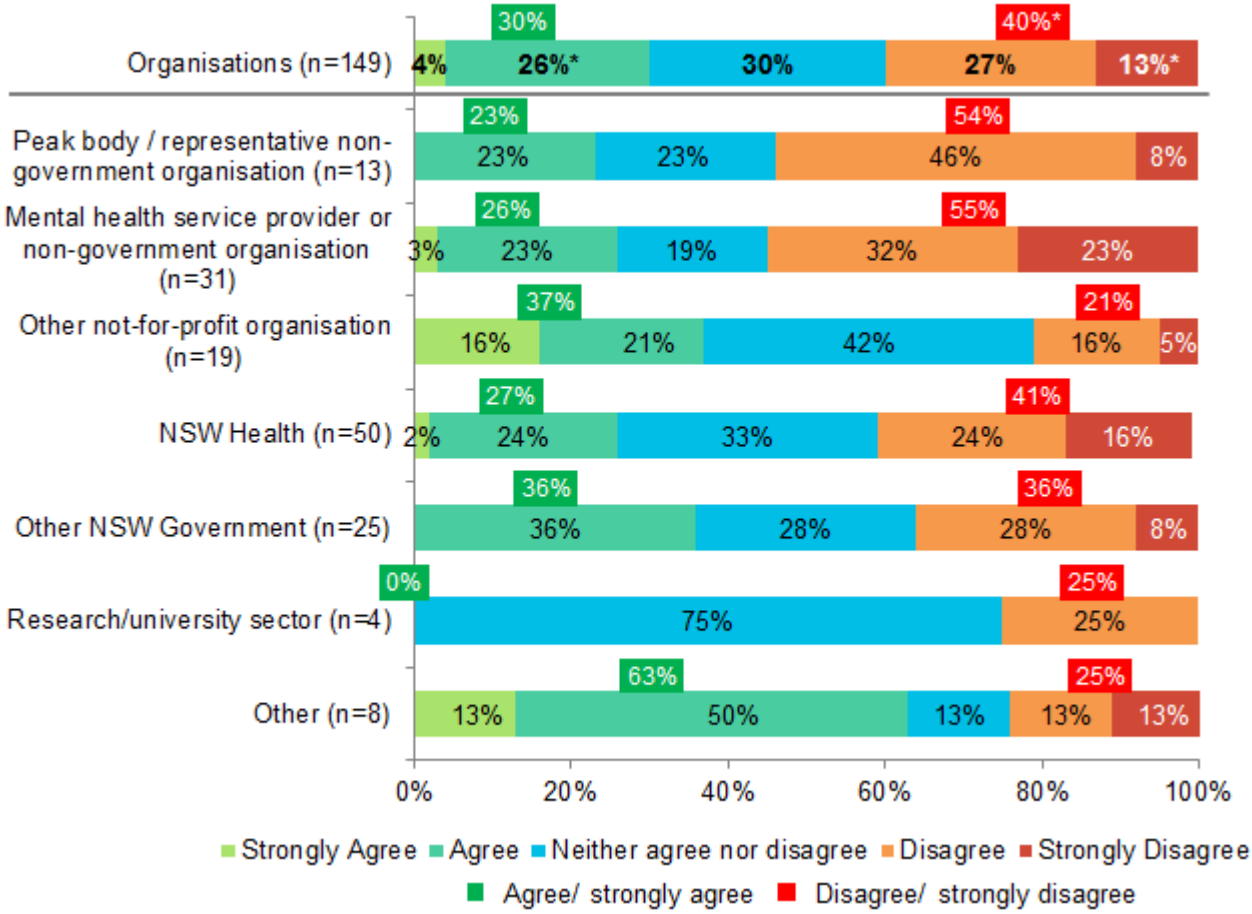
Levels of agreement ranged from 19% of people with lived experience/their carers to 30% of NSW Government and 31% of other organisations. Just over a quarter (27%) of the group comprising health professionals and other individuals agreed with this statement.

Figure 71: Level of agreement that the Commission effectively *ensured that the NDIS take appropriate account of the needs of people with psychosocial disability as a consequence of mental illness*, overall and by high level organisation and individual groupings (n=360)



Unusually, there was no statistically significant difference between the submissions from organisations and individuals in this respect. As shown in Figure 72, three in ten organisations (30%) agreed/ strongly agreed with this measure, ranging from none of the eight academics through to 63% in the 'other' category. Around a quarter of submissions from peak bodies (23%), mental health service providers (26%) and NSW Health submissions (27%) agreed/ strongly agreed with this statement; as did over a third of 'other' not for profits (37%) and 'other' NSW government (36%).

Figure 72: Organisations' level of agreement that the Commission effectively *ensured that the NDIS take appropriate account of the needs of people with psychosocial disability as a consequence of mental illness*, overall and by organisation type (n=149)



Individuals with lived experience of mental illness were significantly less likely to agree with this statement (11%). This compared with 23% of individuals overall, and 27% of family members/carers. (See Figure 73.)

Figure 73: Individuals' level of agreement that the Commission effectively *ensured that the NDIS take appropriate account of the needs of people with psychosocial disability as a consequence of mental illness*, overall and by individual background (n=211)

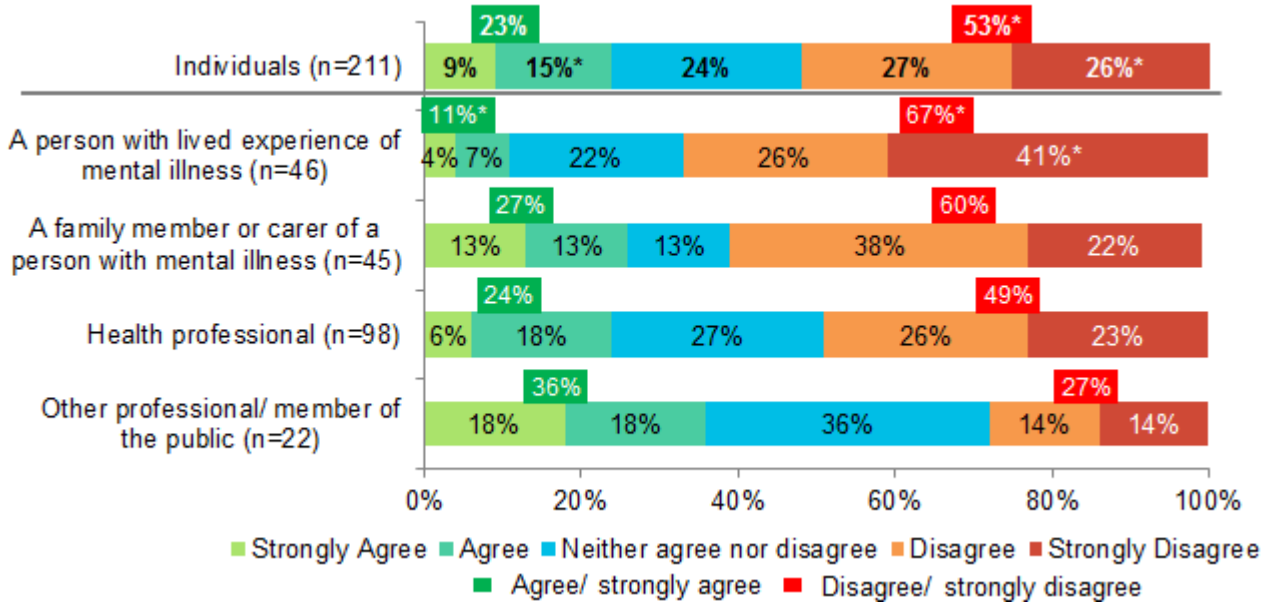
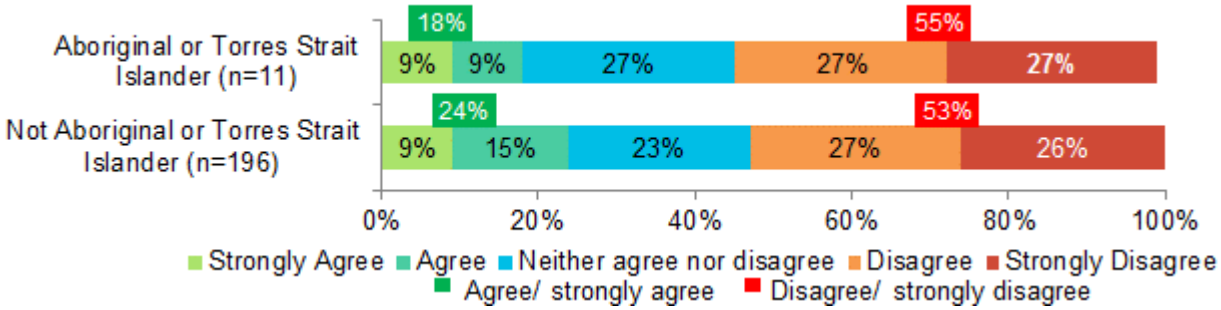



Figure 74: Level of agreement that the Commission effectively *ensured that the NDIS take appropriate account of the needs of people with psychosocial disability as a consequence of mental illness*, by Aboriginal and Torres Strait Islander origin (n=207)



There was large variation by CALD status (although this was not statistically significant). (See Figure 75.)

Figure 75: Level of agreement that the Commission effectively *ensured that the NDIS take appropriate account of the needs of people with psychosocial disability as a consequence of mental illness*, by culturally and linguistically diverse categories (n=207)

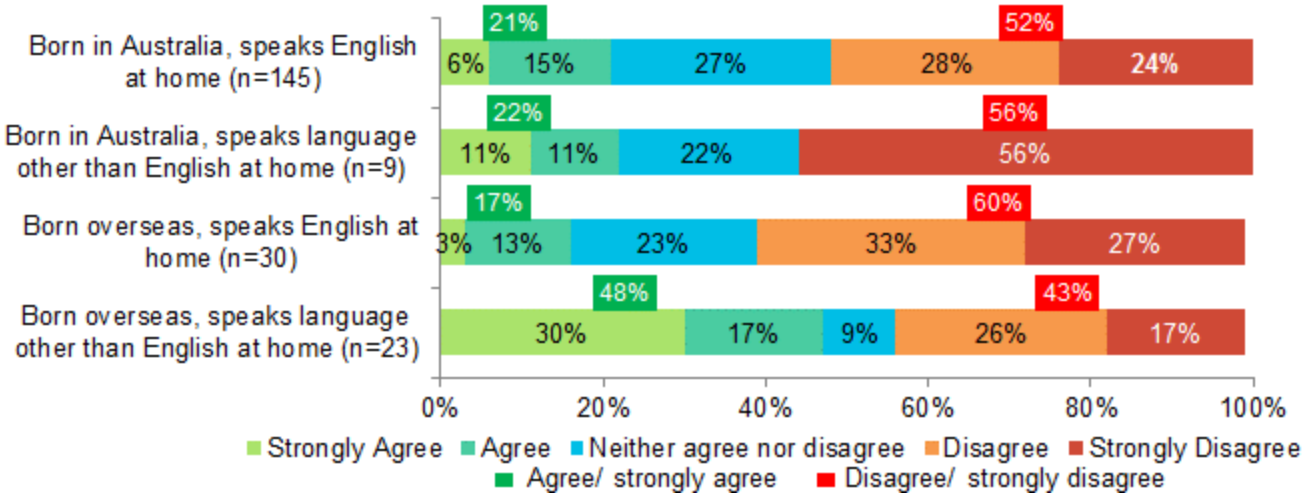
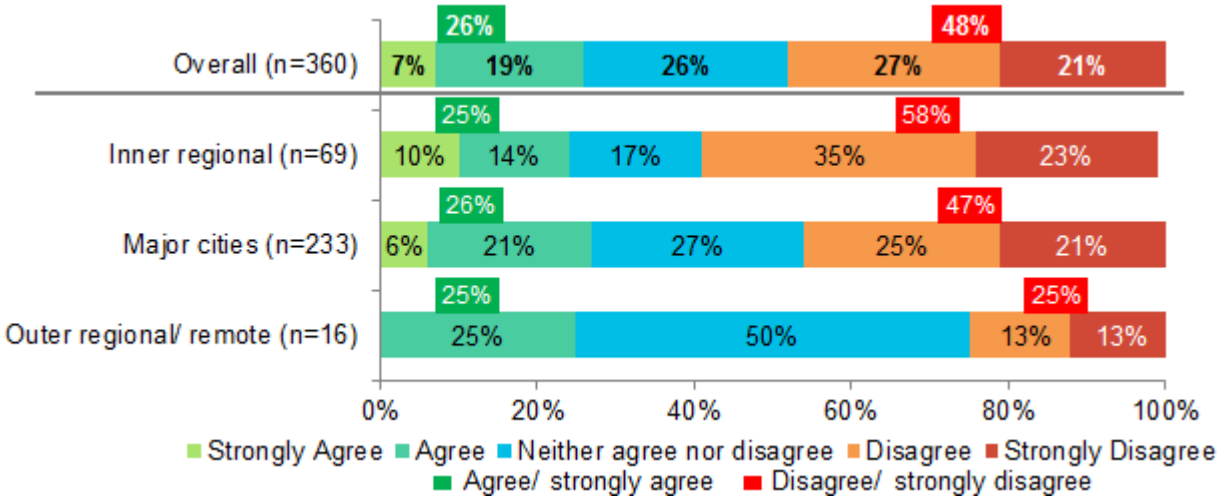



Figure 76: Level of agreement that the Commission effectively *ensured that the NDIS take appropriate account of the needs of people with psychosocial disability as a consequence of mental illness*, overall and by remoteness category (n=360)



## 6.2 Charter letter priority: young people

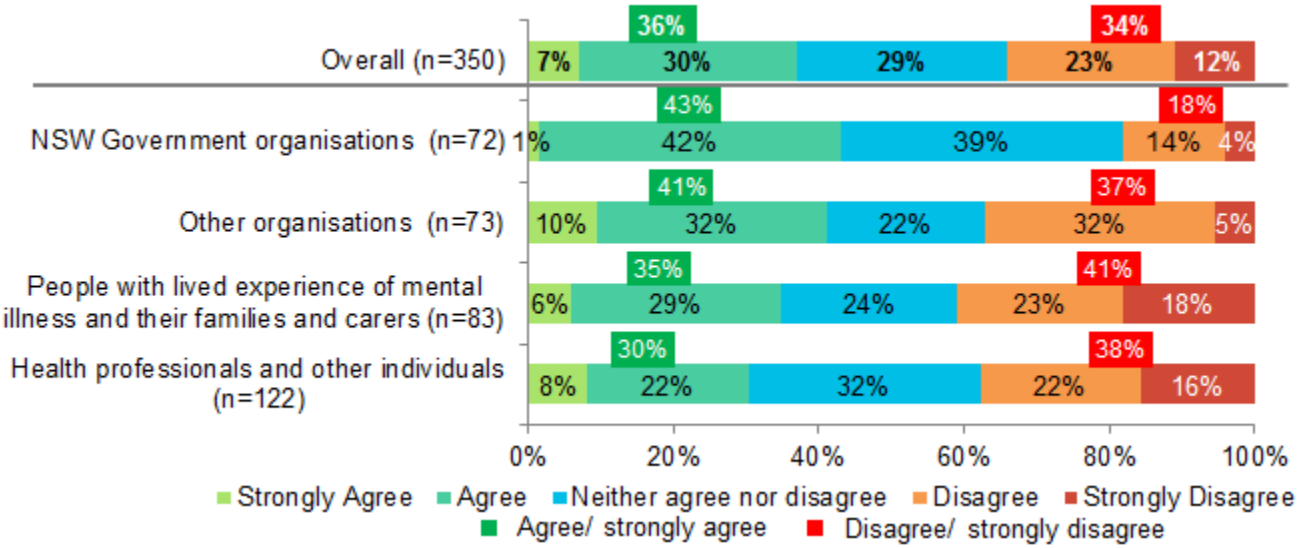
A separate question asked submission respondents to indicate the extent to which they agreed that the Commission had developed innovative responses to the particular mental health needs of young people.

Unfortunately, the number of submissions from people aged 24 or under (n=2) was too small to analyse separately, so did not provide any insights into the views of young people on the Commission's success in this area.

As shown in Figure 77, over a third of submissions (36%) agreed/ strongly agreed with this premise, while just under a third (34%) disagreed/ strongly disagreed.

Organisations forming part of NSW Government (43%) and other organisations (41%) were the most likely to endorse this statement; while non-consumer individuals (including health professionals) were the least likely (30%). Just over a third (35%) of people with lived experience of mental illness and their carers felt that the Commission had effectively responded to the needs of young people.

Figure 77: Level of agreement that the Commission effectively *developed innovative responses to the particular mental health and wellbeing needs of young people*, overall and by high level organisation and individual groupings (n=350)



Once again, submissions representing organisations were significantly more positive than those from individuals (42% and 32% respectively). Variation was less marked within the two segments than for many of the other measures.

As shown in Figure 78, just under a third of peak bodies agreed/ strongly agreed (31%), 33% of not for profits, 39% of NSW Health and 50% of 'other' NSW Government submissions.

Figure 78: Organisations' level of agreement that the Commission effectively *developed innovative responses to the particular mental health and wellbeing needs of young people*, overall and by organisation type (n=145)

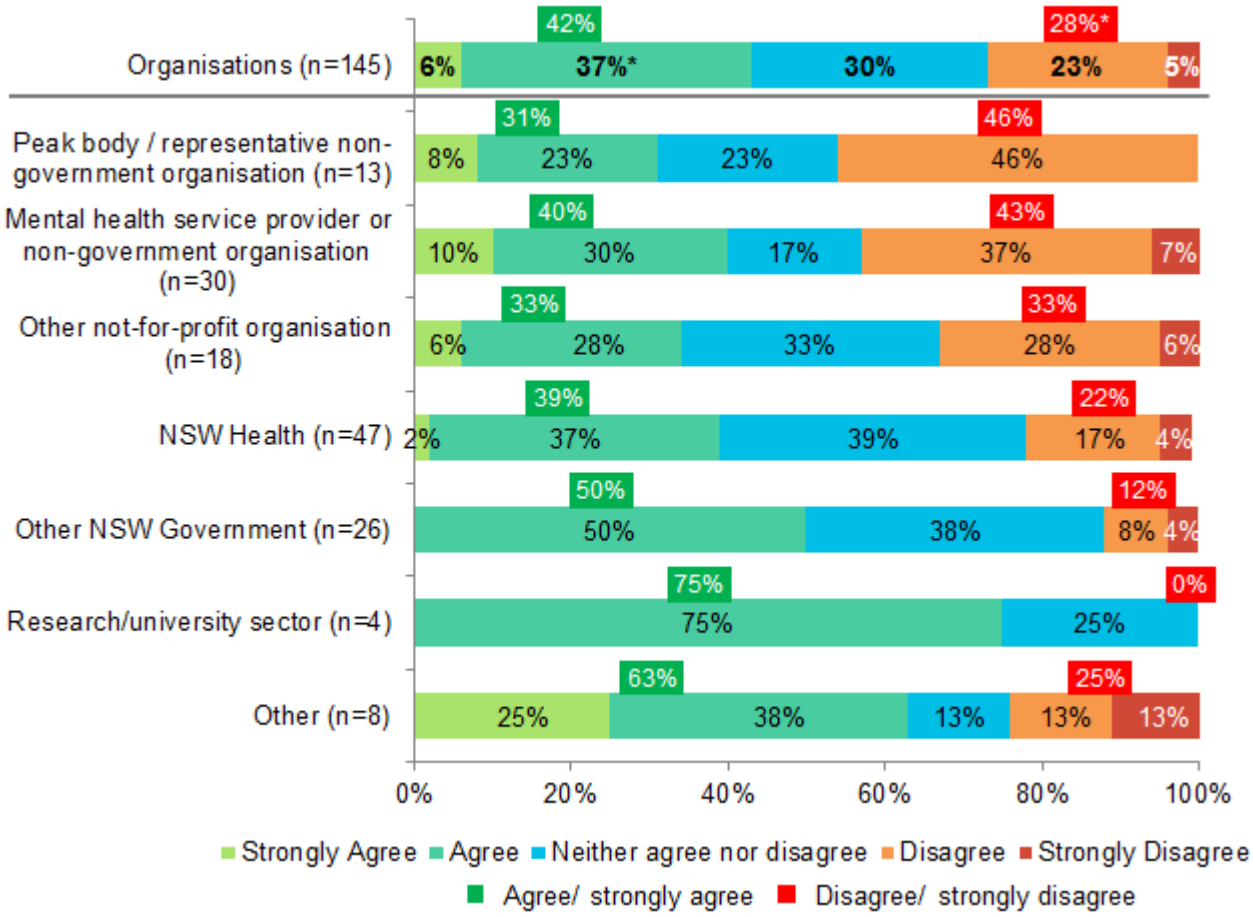
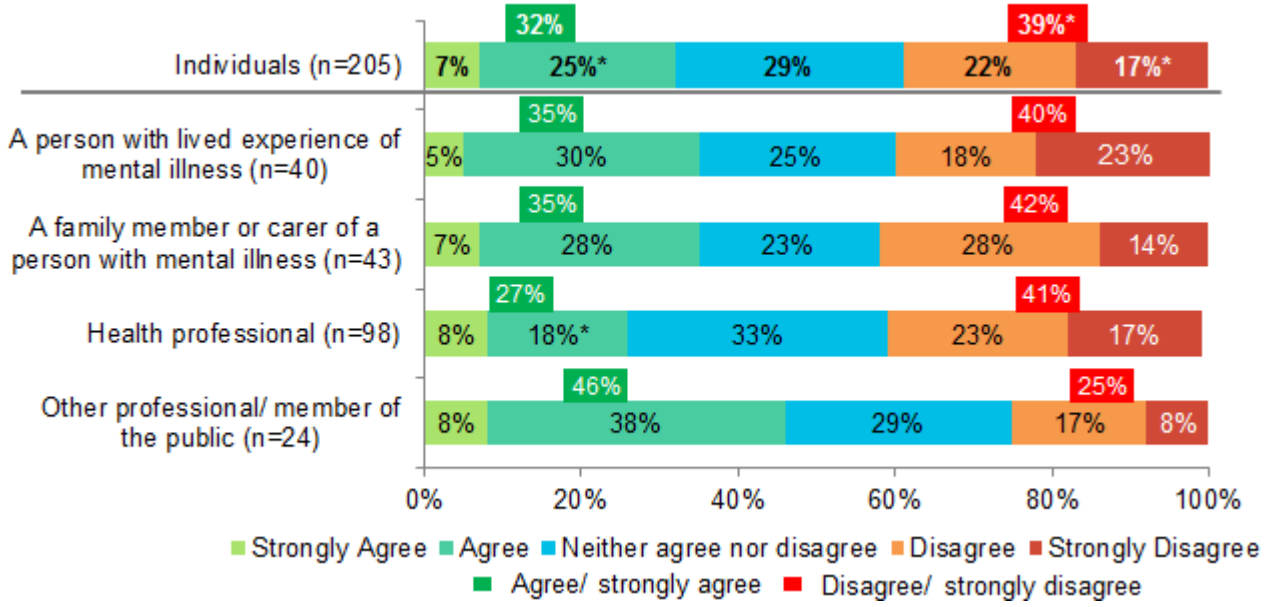


Figure 79: Individuals' level of agreement that the Commission effectively *developed innovative responses to the particular mental health and wellbeing needs of young people*, overall and by individual background (n=205)




Aboriginal Australians (45%) were more likely to agree/ strongly agree with this statement than others (32%), but the difference was not significant. (See Figure 80.)

Figure 80: Level of agreement that the Commission effectively *developed innovative responses to the particular mental health and wellbeing needs of young people*, by Aboriginal and Torres Strait Islander origin (n=201)

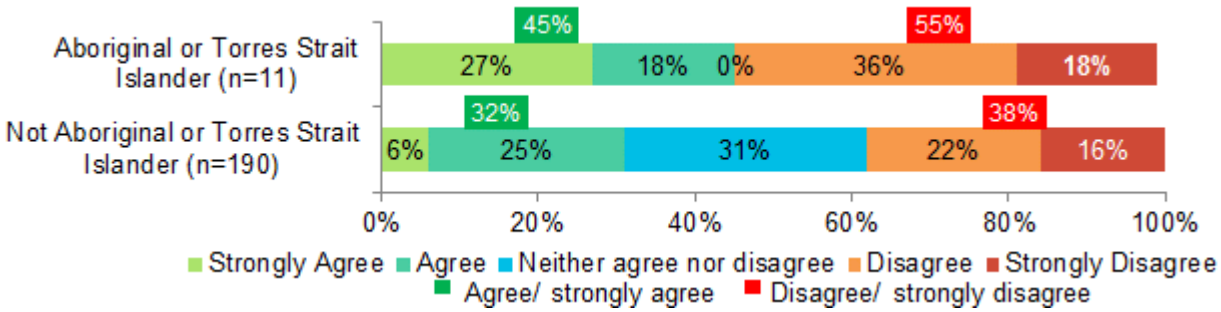


Figure 81: Level of agreement that the Commission effectively *developed innovative responses to the particular mental health and wellbeing needs of young people*, by culturally and linguistically diverse categories (n=201)

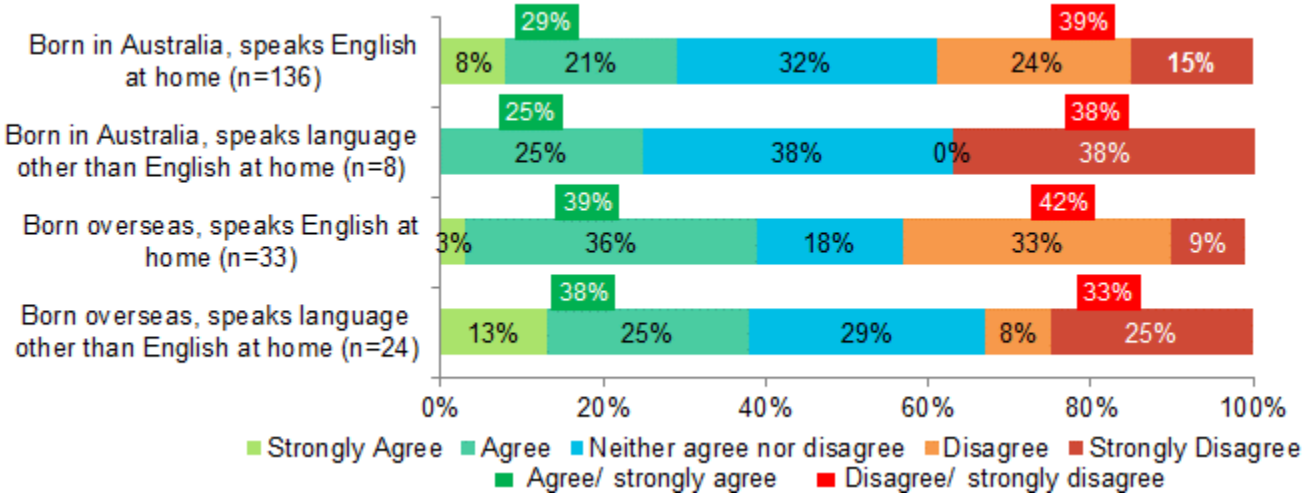
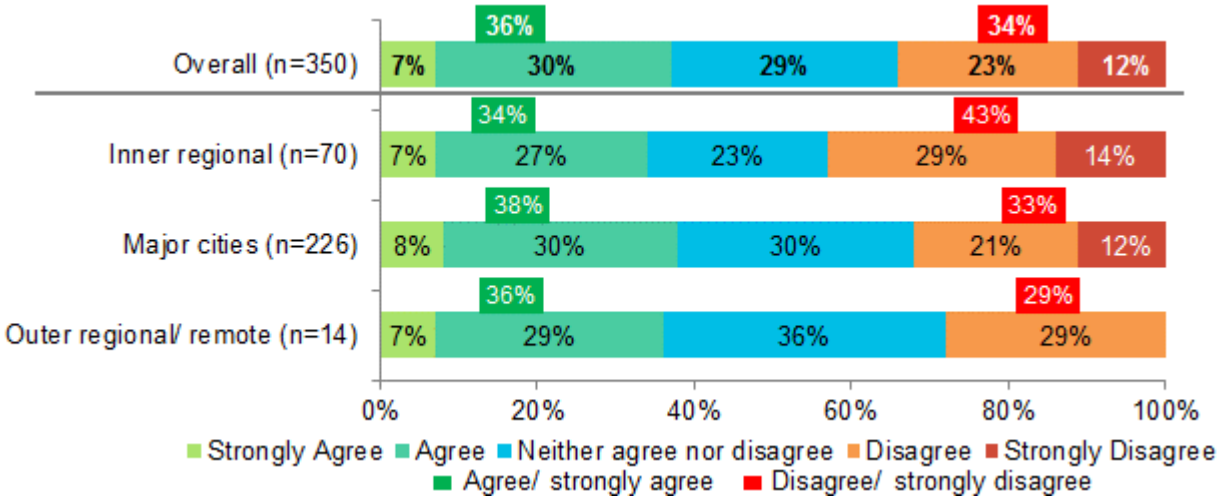



Figure 82: Level of agreement that the Commission effectively *developed innovative responses to the particular mental health and wellbeing needs of young people*, overall and by remoteness category (n=350)



# 7 Operations – The exercising of the Commission's functions

In section 3.12.2, The Act listed a number of ways the Mental Health Commission was to exercise its functions, as also defined under the Act. This section reviews the Commission's operations in relation to these requirements.

Positivity in the measures of how the Commission had exercised its functions ranged from 37% to 58% of respondents.

The highest proportions of respondents agreed that the Commission had:

- focused on system wide mental health issues (58%)
- effectively engaged and consulted with NSW Government (58%)
- effectively engaged and consulted with families and carers of people with a lived experience of mental illness (55%).

The measures that the lowest proportions of respondents agreed/ strongly agreed with were: engagement and consultation with *the whole community* (37%), and having taken into account the interaction between people who have a mental illness and the criminal justice system (43%).

A pattern emerged in terms of differences in results between the four key segments, with NSW Government and other organisations being most likely to endorse the work of the Commission on these measures (as they had been for its function measures); and individuals with lived experience of mental illness, their families and carers and the group of health professionals/other individuals being least positive. In some instances, health professionals were even less positive than consumers and their families and carers. These individuals tended to comment on the lack of improvements in the sector, at the service delivery level.

When it came to the indicators around the Commission's work in addressing the needs of minority communities; the segments in question were less likely than other respondents to endorse the Commission. For example, Aboriginal Australians were less likely than other Australians to agree that the Commission is addressing the needs of Aboriginal Australian.

# 7.1 System-wide focus

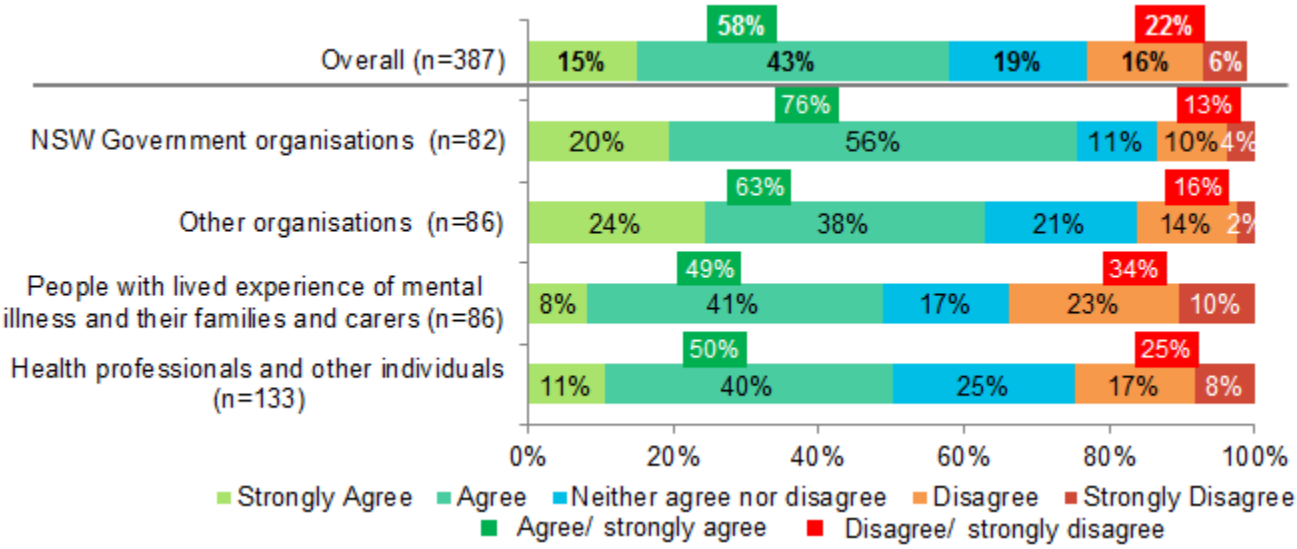
The Act required the Commission to *focus on systemic mental health issues*.

## 7.1.1 Focus on system-wide mental health issues

The majority (58%) of consultation responses agreed that the Commission had focused on system wide mental health issues, and just over one fifth (22%) agreed with this statement. The remaining fifth were neutral.

There was a good deal of variation in levels of agreement between the broad segments of submissions. People with mental illness and their carers (49%) and also health professionals/other individuals (50%) had relatively low levels of endorsement. Submissions from the NSW Government were the most positive (76%).

Figure 83: Level of agreement that the Commission's work has *focused on system wide mental health issues*, overall and by high level organisation and individual groupings (n=387)




As shown in Figure 84 and Figure 85, organisations were more positive than individuals in regard to this dimension, with 69% and 50%, respectively, agreeing with the statement. Although there was quite wide variation between organisations in the proportion agreeing with the statement, and also between the segments of individuals, these were not large enough to be statistically significant within the small sample sizes (for some of the categories). Within organisations, peak bodies/NGOs had particularly low levels of agreement (27%), while those representing the NSW government were particularly positive (75-76%) as were the research/university sector (100% agreement). Variation within individuals (i.e. those not representing organisations) were less marked, although it was notable that respondents who were born in Australia and spoke a language other than

English at home were much more positive (75% agreement) than the other CALD groups (49%-52%). (See Figure 85 to Figure 87.)

Figure 84: Organisations' level of agreement that the Commission's work has *focused on system wide mental health issues*, overall and by organisation type (n=168)

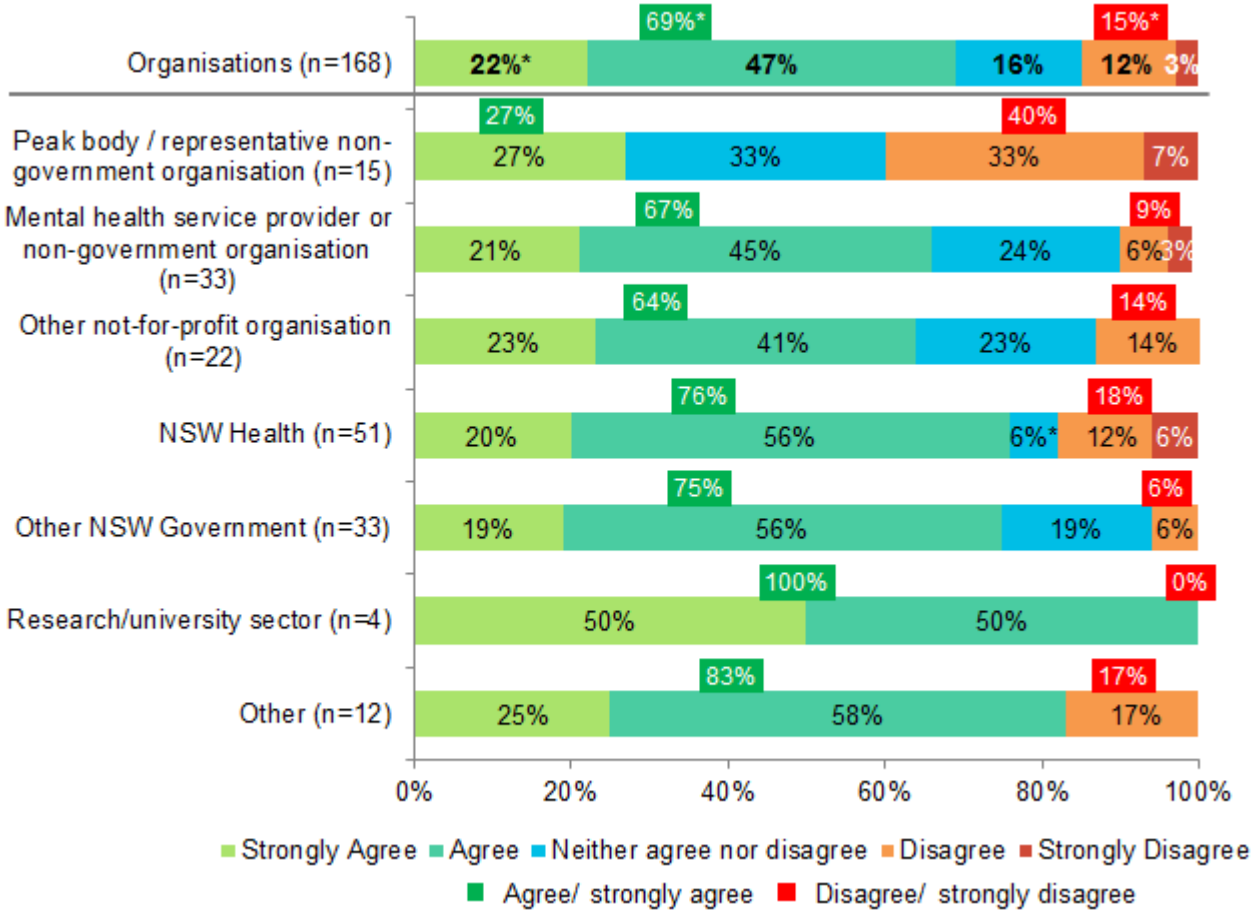


Figure 85: Individuals' level of agreement that the Commission's work has *focused on system wide mental health issues*, overall and by individual background (n=219)

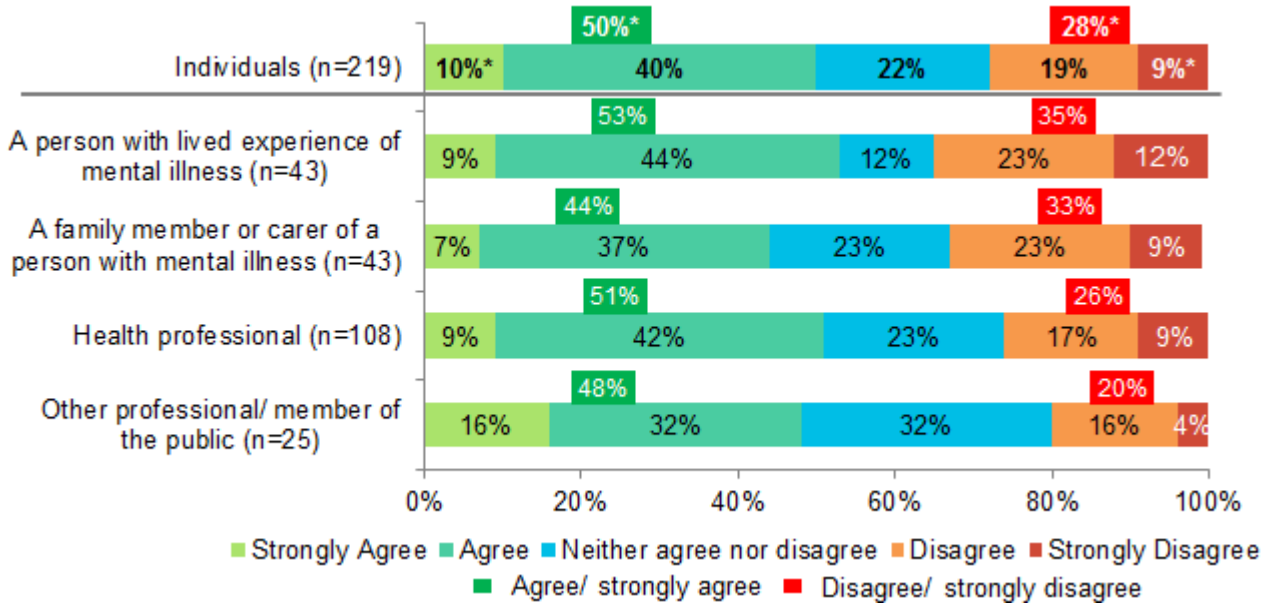



Figure 86: Level of agreement that the Commission's work has *focused on system wide mental health issues*, by Aboriginal and Torres Strait Islander origin (n=215)

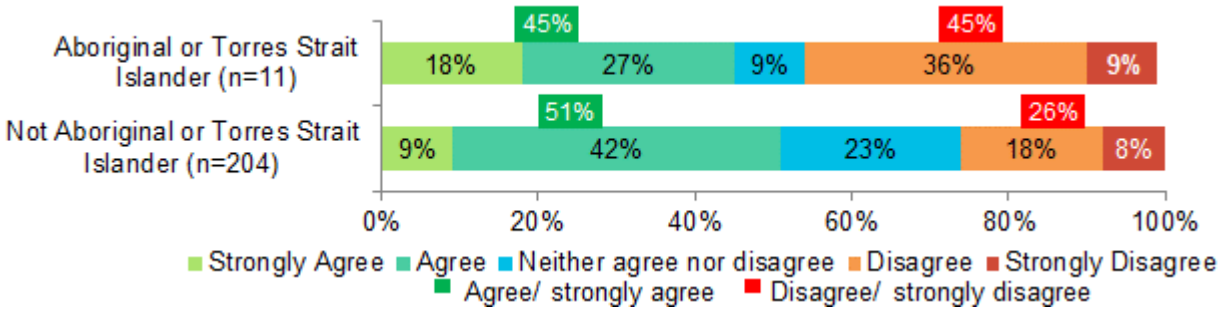
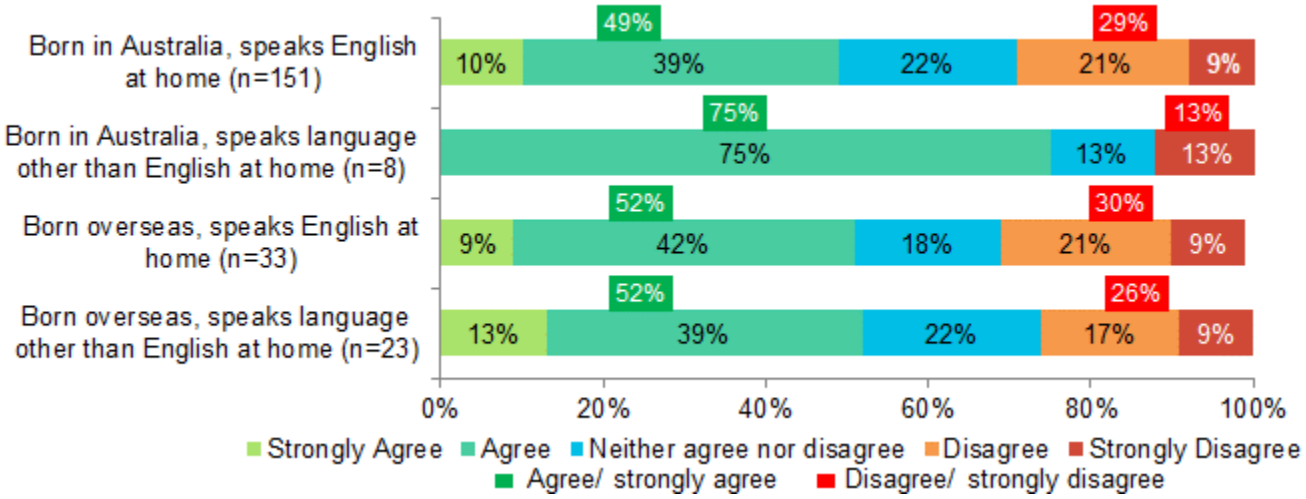
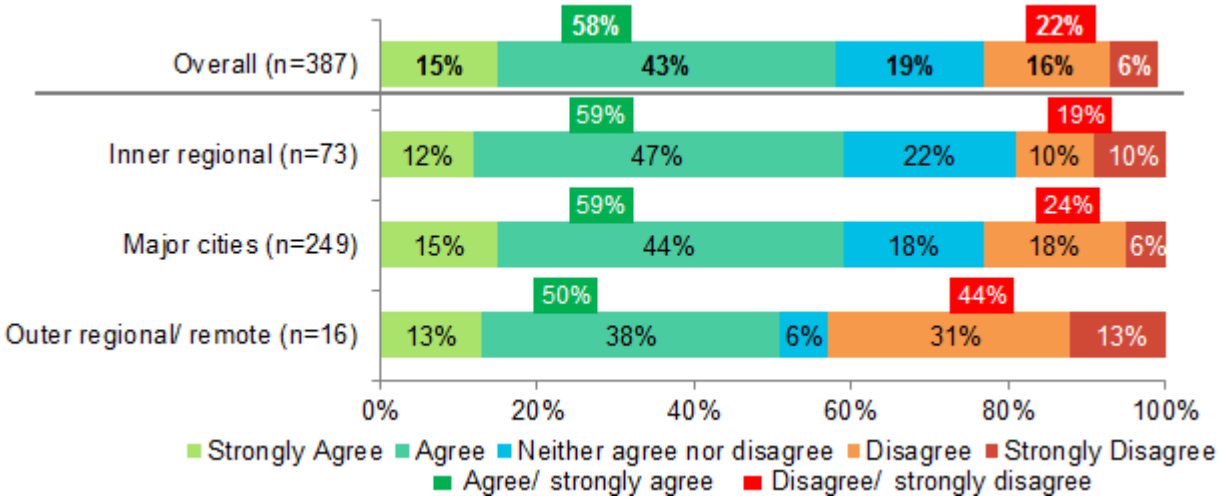


Figure 87: Level of agreement that the Commission's work has *focused on system wide mental health issues*, by culturally and linguistically diverse categories (n=215)




Submissions from outer regional and remote locations were more polarised in response to this statement, with 44% indicating that they disagreed that the Commission's focus was system wide and 50% agreeing (and only 6% indicating neither agreement nor disagreement). However, these results were not significantly different from the overall results, because of the small sample size in the outer regional/remote category.

Figure 88: Level of agreement that the Commission's work has *focused on system wide mental health issues*, overall and by remoteness category (n=387)



### 7.1.2 The impact of the Mental Health Commission's system-wide focus

Respondents who had provided any agreement rating at the question about the Commission having focused on system-wide mental health issues were asked for an example of the Commission successfully having done this, and to describe the impact of their example.

A third of respondents thought that the Commission had not focused on system-wide issues, or that its focus had been "piecemeal", with "lots of words on paper, lots of nice documents - little action and no change on the ground" (34%). When respondents were positive about the impacts, it was most often about there now being a greater focus, in the sector, on the needs of consumers and support provision for people with mental illness and their families and carers (17%), and about better collaboration between all the various agencies (15%).

Again, individuals (including those with lived experience, carers, mental health professionals and others) were the most likely to raise something negative in response to this consultation question.

Table 46: Top three examples of having a system-wide focus, overall and by high level organisation and individual groupings

| Topics | n= | Overall 131 | NSW Government organisations 32 | Other organisations 26 | People with lived experience of mental illness and their families and carers 25 | Health professionals and other individuals 48 |
|---|---|---|---|---|---|---|
| Negative comments/ impacts/ issues with implementation | | 34% | 19% | 27% | 44% | 42% |
| Greater user focus/ lived experience | | 17% | 9% | 27% | 24% | 13% |
| Collaboration between agencies | | 15% | 19% | 27% | - | 13% |
| Public awareness | | 10% | 19% | 4% | 8% | 8% |
| Other long term strategies | | 8% | 9% | 8% | 8% | 8% |

Organisations overall were significantly more likely than individuals to mention collaboration across the sector, and cross-government, multi-agency efforts (22%), and were significantly less likely to talk about a lack of system-wide impacts, although this was still mentioned by a fifth (22%).

Table 47: Top three examples of having a system-wide focus mentioned by organisations, overall and by organisation types

| Topics | n= | Organisations overall 58 | Peak body / representative non-government orgs 5 | Mental health service provider or non-gov org 12 | NSW Health 18 | Other NSW Government 14 | Research/university sector 1 | Other not-for-profit org 5 | Other 3 |
|---|---|---|---|---|---|---|---|---|---|
| Collaboration between agencies | | 22%* | 20% | 33% | 11% | 29% | 100 % | - | 33% |
| Negative comments/ impacts/ issues with implementation | | 22%* | 60% | 17% | 28% | 7% | - | - | 67% |
| Greater user focus/ lived experience | | 17% | 20% | 25% | 6% | 14% | - | 60% | - |
| Public awareness | | 12% | - | - | 22% | 14% | - | 20% | - |
| Other long term strategies | | 9% | 20% | - | 11% | 7% | - | 20% | - |
| Focus on physical health | | 3% | 20% | - | 6% | - | - | - | - |
| Living Well | | 7% | 20% | 8% | 6% | 7% | - | - | - |
| Suicide prevention | | 5% | - | - | 6% | 14% | - | - | - |
| Reduced stigma/ discrimination | | 5% | - | - | 6% | 7% | - | 20% | - |
| Wellbeing Collaborative | | 7%* | - | - | - | 29% | - | - | - |

Some examples of verbatim comments provided by respondents include:

> *"Consultation with different sectors."* [NSW Health]
>
> *"The work on corrections mental health has brought together a disparate and desperately needy sector."* [Research/university sector]

*"System-wide issues are addressed in the strategic plan and the 'One year on' report, but I can't see a link between that and people's lives."* [Other NSW Government]

*"I think each health district may be different, but in our area, a focus on youth mental health has been evident and has included the health and community sectors."* [Other not-for-profit organisation]

*"Greater public awareness of the contribution of psychiatry and psychology to mental health care."* [NSW Health]

*"NSW suicide prevention advisory group."* [NSW Health]

*"Wellbeing Collaborative."* [Other NSW Government]

Forty-two percent of individuals overall (42%), 57% of people with a lived experience of mental illness, and half of health professionals (49%), did not think the Commission had successfully focused on system-wide mental health issues, or saw little impact from its efforts to do so. However, about a third of people with a lived experience expressed some pleasure that their own needs were being taken more into account, recognising "positive step[s] towards a more person-centred approach" (36%, compared to 9%-29% of individuals from other backgrounds).

Table 48: Top three examples of having a system-wide focus mentioned by individuals, overall and by individual background

| Topics | n= | Individuals overall | A person with lived experience of mental illness | A family member or carer of a person with mental illness | Health professional | Other professional/ member of the public |
|---|---|---|---|---|---|---|
| | | 73 | 14 | 11 | 41 | 7 |
| Negative comments/ impacts/ issues with implementation | | 42%* | 57% | 27% | 49% | - |
| Greater user focus/ lived experience | | 16% | 36% | 9% | 10% | 29% |
| Public awareness | | 8% | - | 18% | 7% | 14% |
| Other long term strategies | | 8% | 7% | 9% | 7% | 14% |

| Topics | n= | Individuals overall | A person with lived experience of mental illness | A family member or carer of a person with mental illness | Health professional | Other professional/ member of the public |
|---|---|---|---|---|---|---|
| | | 73 | 14 | 11 | 41 | 7 |
| Collaboration between agencies | | 8%* | - | - | 10% | 29% |
| NDIS | | 4% | - | 9% | 2% | 14% |
| Reduced stigma/ discrimination | | 1% | 7% | - | - | - |
| Communication/ publications/ information | | 5% | 7% | - | 5% | 14% |

Some examples of verbatim comments provided by respondents include:

*"I don't think it has [had an impact]. I think the focus has been piecemeal."* [Health professional]

*"It hasn't successfully focused, except by funding NGOs, who do nothing."* [A person with lived experience of mental illness]

*"Through its emphasis on consultation with people who have mental health issues, carers and professionals, the Commission has effectively united the efforts of disparate groups. However, the NSW State Government has not responded with suitable funding arrangements and thus the Commission's recommendations have had limited real impact on the sector to date."* [A family member or carer of a person with mental illness]

*"More media articles and events."* [Other professional]

*"The Commission's support for the National Aboriginal and Torres Strait Islander Leadership in Mental Health group has been outstanding. NATSILMH would not have been able to achieve the things it has (such as the Gayaa Dhuwi (Proud Spirit) Declaration, without the Commission's financial and other support."* [Other professional]

*"Representation at national MHC meetings and strategic discussions with the Mental Health Branch at the Ministry of Health."* [Health professional]

Table 49: Top three examples of having a system-wide focus, by Aboriginal and Torres Strait Islander origin

| Topics n= | Aboriginal 3 | Not Aboriginal 70 |
|---|---|---|
| Negative comments/ impacts/ issues with implementation | 67% | 41% |
| Greater user focus/ lived experience | - | 17% |
| Other long term strategies | - | 9% |
| Public awareness | - | 9% |
| Collaboration between agencies | - | 9% |
| Living Well | - | 6% |
| Reduced stigma/ discrimination | 33% | - |
| Communication/ publications/ information | 33% | 4% |

Some examples of verbatim comments provided by respondents include:

ABORIGINAL AND TORRES STRAIT ISLANDERS:

> *"It hasn't successfully focused, except by funding NGOs, who do nothing."* [A person with lived experience of mental illness]
>
> *"Review of transparency and accountability of mental health funding to health services paper. Stigma and discrimination in NSW paper."* [A person with lived experience of mental illness]

The same themes of minimal impacts, but some increase in the patient focus, recurred to a similar degree between CALD groups, as shown in Table 50.

Table 50: Top three examples of having a system-wide focus, by culturally and linguistically diverse categories

| Topics n= | Born in Australia, speaks English at home 52 | Born in Australia, speaks language other than English at home 2 | Born overseas, speaks English at home 12 | Born overseas, speaks language other than English at home 6 |
|---|---|---|---|---|
| Negative comments/ impacts/ issues with implementation | 46% | - | 33% | 50% |
| Greater user focus/ lived experience | 17% | 50% | 8% | - |
| Public awareness | 8% | - | 17% | - |
| Other long term strategies | 8% | - | 8% | 17% |
| Collaboration between agencies | 8% | - | 17% | - |
| Living Well | 8% | - | - | - |
| Seclusion & Restraint review | - | 50% | - | - |
| Communication/ publications/ information | 4% | - | 8% | 17% |

Some examples of verbatim comments provided by respondents include:

BORN IN AUSTRALIA, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

> *""In-patient and out-patient programs have helped individuals and their families, friends and carers to gain a better understanding of the differences and similarities of all the different mental health issues. As a result, I believe that everybody has been able to identify common ground to provide one another with support, empathy and understanding."* [A person with lived experience of mental illness]
>
> *"Seclusion review."* [Health professional]

BORN OVERSEAS, SPEAKS ENGLISH AT HOME:

*"The Commission's abandonment of any focus on transcultural mental health is sinful. I struggle to see any true or unbiased consultative processes."* [Health professional]

*"The Commission has been very focused on mental health services; I don't know if it has engaged with the education or housing services."* [Health professional]

*"There is definitely increased awareness of the needs of and difficulties faced by those suffering mental illnesses."* [A family member or carer of a person with mental illness]

*"The Justice report was wide-ranging in scope and took a total system approach encompassing many groups."* [Other professional]

BORN OVERSEAS, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

*"It focused again on professionals and services; that is a dead end. The focus should be on people and those experiencing mental health issues."* [Health professional]

*"The Partners in Recovery project, which in western Sydney, also had support for mental health literacy for CALD communities."* [A person with lived experience of mental illness]

*"The Commission has made data more accessible … they worked with government, the Australian Bureau of Statistics and universities to build a suite of interactive data presentations and snapshots that make NSW mental health-related data more accessible to everyone."* [Other professional]

Table 51: Top three examples of having a system-wide focus, overall and by remoteness category

| | | Overall | Major cities | Inner regional | Outer regional / remote |
|---|---|---|---|---|---|
| **Topics** | **n=** | **131** | **83** | **23** | **8** |
| Negative comments/ impacts/ issues with implementation | | 34% | 33% | 43% | 38% |
| Greater user focus/ lived experience | | 17% | 18% | 17% | 13% |
| Collaboration between agencies | | 15% | 14% | 17% | 13% |
| Public awareness | | 10% | 12% | - | 13% |
| None/ no impact | | 1% | - | - | 13% |

| Topics | n= | Overall 131 | Major cities 83 | Inner regional 23 | Outer regional / remote 8 |
|---|---|---|---|---|---|
| Suicide prevention | | 3% | 2% | - | 13% |
| Reduced stigma/ discrimination | | 3% | 2% | 4% | 13% |

Some examples of verbatim comments provided by respondents include:

MAJOR CITIES:

*"I do not believe it has been successful. Lots of words on paper, lots of nice documents, but little action and no change on the ground."* [Health professional]

*"The Commission has not been able to address the important system-wide issues, due to design faults in its legal powers, structure and funding."* [Health professional]

*"Organising workshops that engage with individuals and families with a lived experience of mental illness, where they can talk about their experience of the mental health system."* [Health professional]

*"Cross agency consultations."* [Mental health service provider or non-government organisation]

INNER REGIONAL:

*"I am unable to answer for a successful outcome yet; I am still waiting for that to happen in my community."* [A family member or carer of a person with mental illness]

*"Great plan, not so great implementation."* [NSW Health]

*"The Commission has started the transition towards true partnership and collaboration with people who have a lived experience of mental illness."* [Health professional]

*"Collaboration with the Department of Education."* [Other NSW Government]

OUTER REGIONAL/REMOTE:

*"No focus on rural areas."* [A person with lived experience of mental illness]

*"Data linkage of medical treatment and illness to other services."* [Mental health service provider or non-government organisation]

*"General education of mental health awareness."* [A family member or carer of a person with mental illness]

*"The MH and Suicide awareness campaigns have had a positive effect on the social stigma which has previously been a stubborn barrier to people actively seeking support and assistant with mental health issues."* [Other NSW Government]

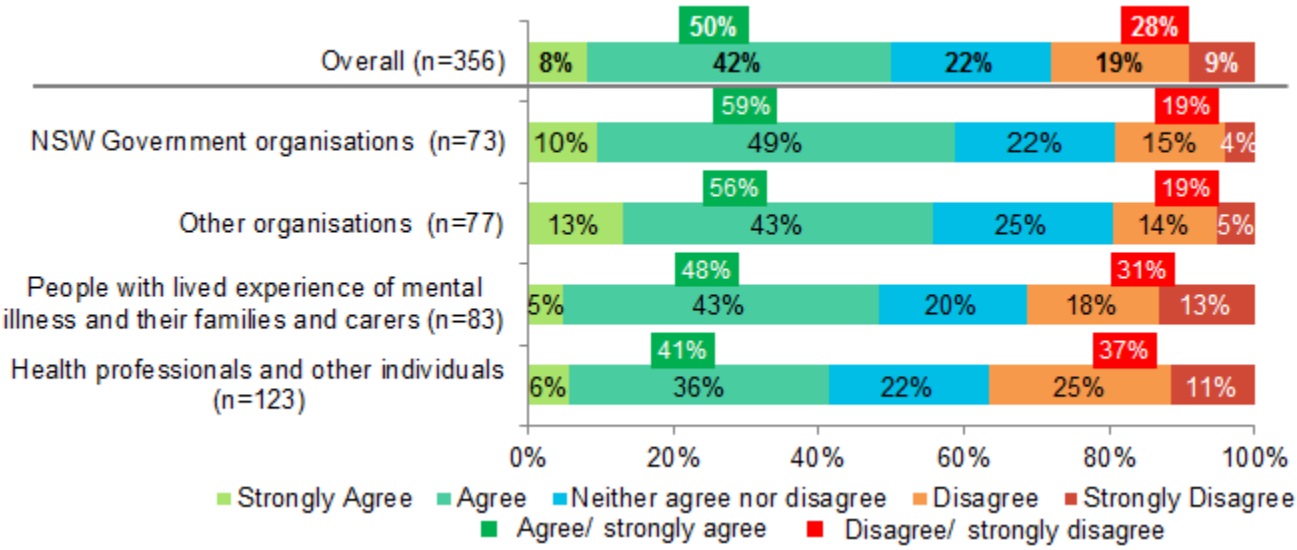
## 7.2 Co-morbidity issues

The Commission was required, under the Act, *to take into account co-morbid issues associated with mental illness, such as drug and alcohol use and disability*.

A half (50%) of submissions agreed that the Commission's work had met the objective of taking into account co-morbidity issues. Just over a quarter (28%) disagreed while just under a quarter remained neutral.

Again, the two least positive segments comprised health professionals/other individuals (41% agreed/strongly agreed) and people with lived experience of mental illness and their carers (48%). This compared with 59% of submissions from NSW Government and 56% of other organisations.

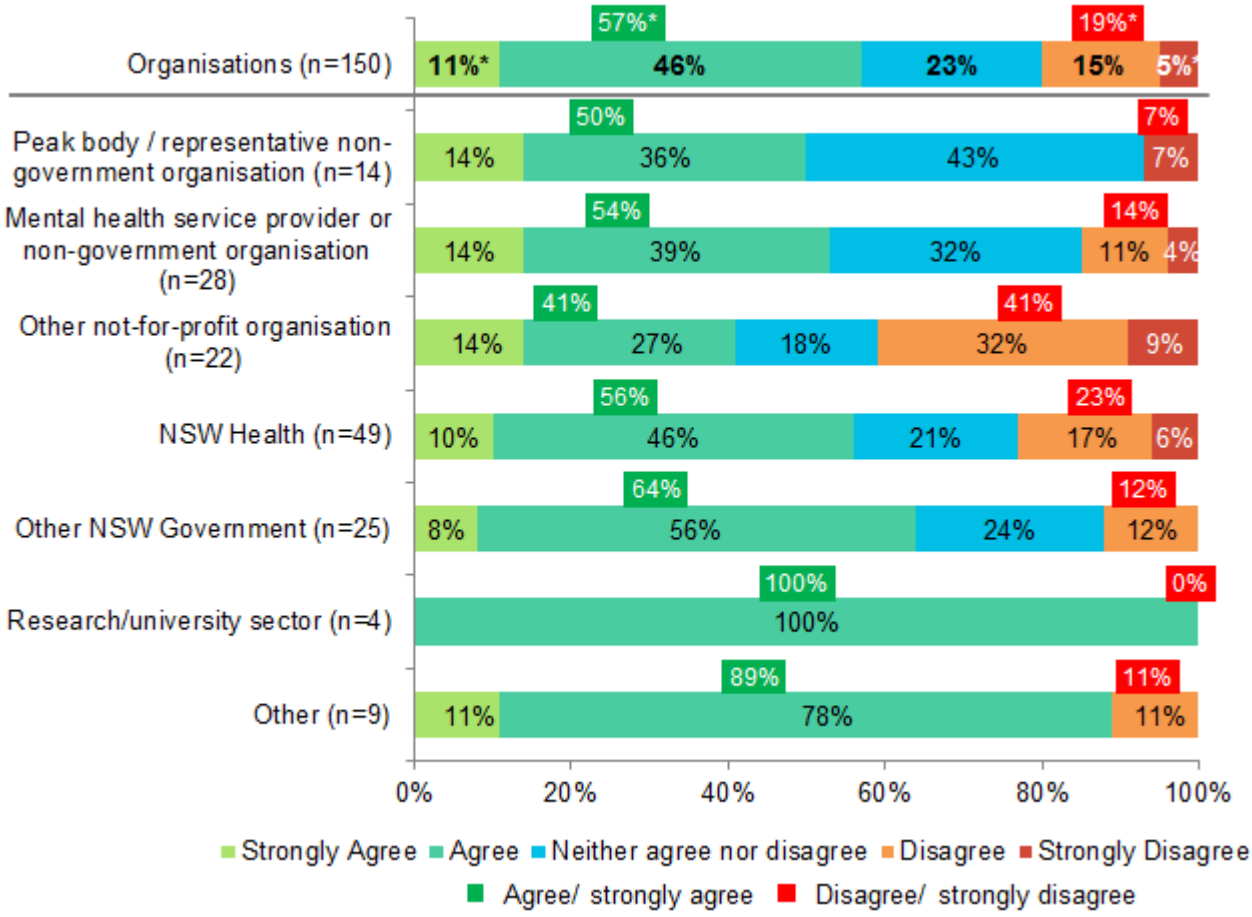
Figure 89: Level of agreement that the Commission's work has taken into account *co-morbidity (e.g. drug and alcohol, disability)*, overall and by high level organisation and individual groupings (n=356)



Again, organisations (57%) were more likely than individuals (44%) to agree with this statement. And again, there was considerable variation between types of organisation, and between segments of individuals, in the proportion agreeing with this statement, but none were statistically significant.

Within organisations, levels of agreement regarding co-morbidity ranged from 41% of 'other' not for profits, through 50%-60% for the majority of organisation types, and peaking at 100% for the research/university sector. (See Figure 90.)

Figure 90: Organisations' level of agreement that the Commission's work has taken into account *co-morbidity (e.g. drug and alcohol, disability)*, overall and by organisation type (n=150)



Among individuals, health professionals had lower levels of positive agreement with the Commission's work around co-morbidity (40%) than people with lived experience of mental illness (52%). (See Figure 91.)

Again, Australians who spoke a language other than English at home were the most positive (67%), and those who were born overseas but spoke only English were the least (30%); but because of small segment sizes these differences were not statistically significant. (See Figure 93.)

Figure 91: Individuals' level of agreement that the Commission's work has taken into account *co-morbidity (e.g. drug and alcohol, disability)*, overall and by individual background (n=206)

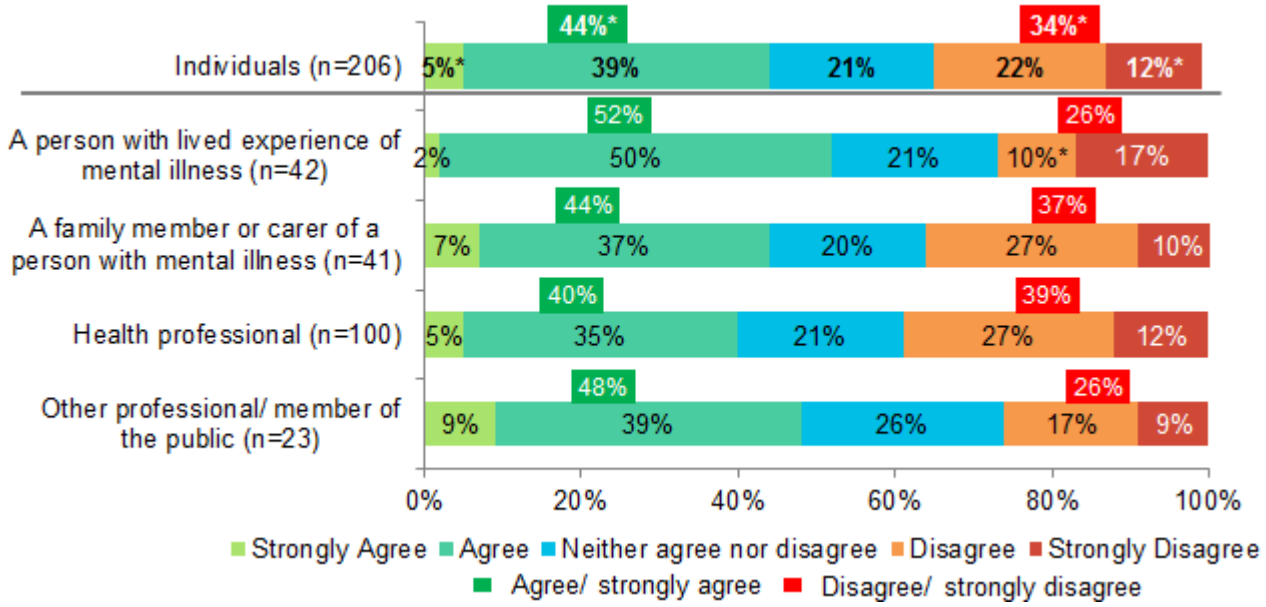



Figure 92: Level of agreement that the Commission's work has taken into account *co-morbidity (e.g. drug and alcohol, disability)*, by Aboriginal and Torres Strait Islander origin (n=202)

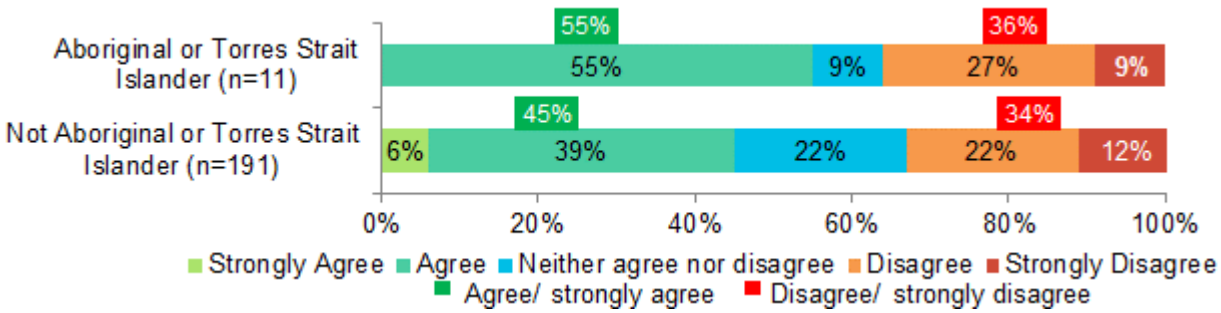


Figure 93: Level of agreement that the Commission's work has taken into account *co-morbidity (e.g. drug and alcohol, disability)*, by culturally and linguistically diverse categories (n=202)

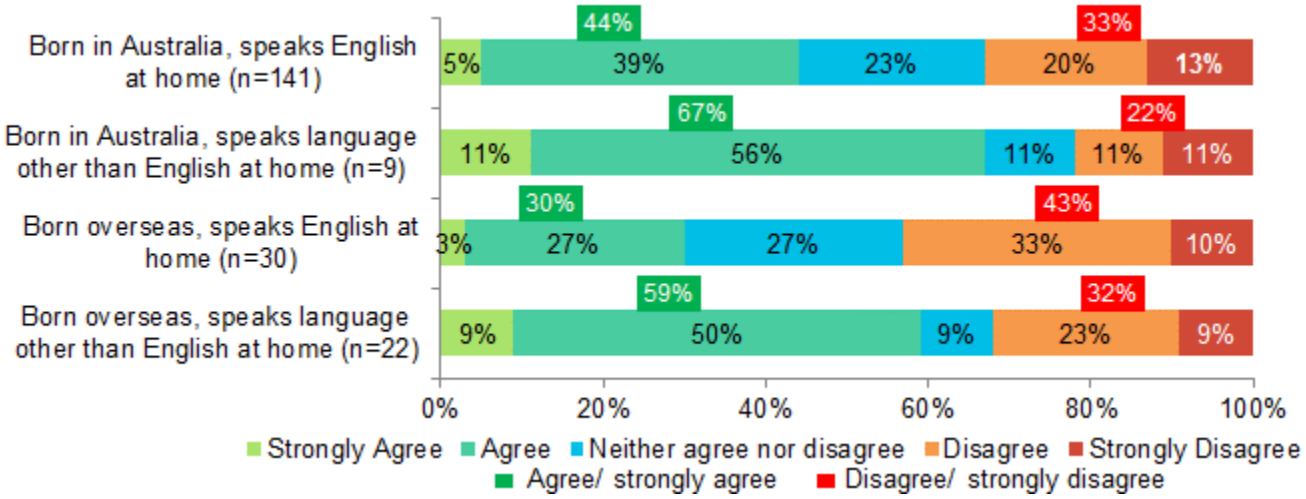
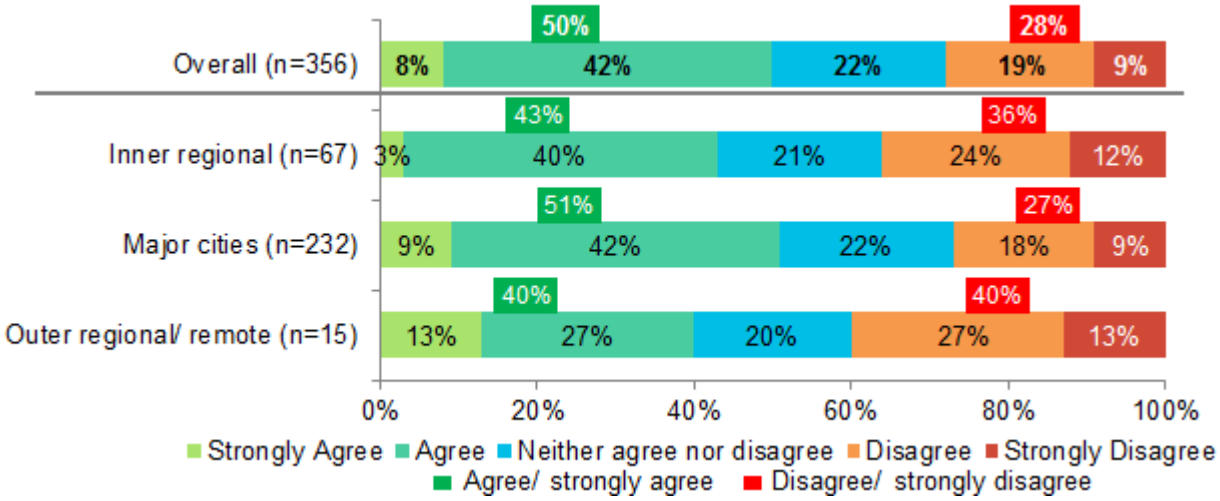



Figure 94: Level of agreement that the Commission's work has taken into account *co-morbidity (e.g. drug and alcohol, disability)*, overall and by remoteness category (n=356)



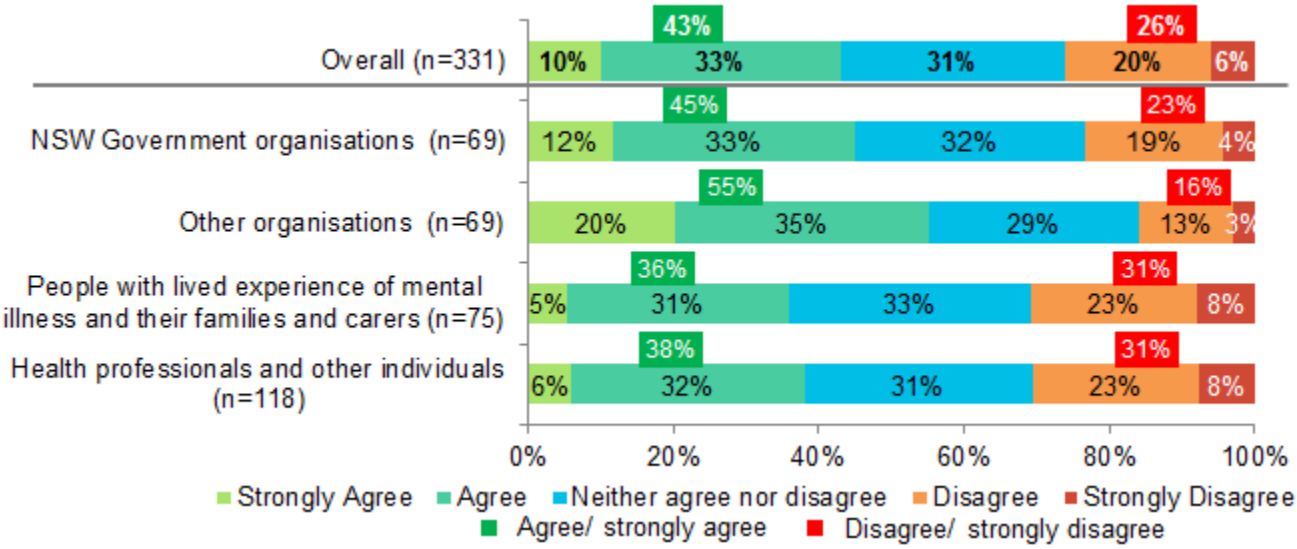
## 7.3 People who have a mental illness, and the criminal justice system

Another requirement under the Act, was for the Commission *to take into account issues related to the interaction between people who have a mental illness and the criminal justice system*.

Levels of agreement were quite low in relation to this measure; with 43% agreeing (strongly agree/agree), 26% disagreeing (disagree/strongly disagree), and 31% indicating that they neither agreed nor disagreed (perhaps indicating a lack of knowledge/awareness of how the Commission is performing in this regard.

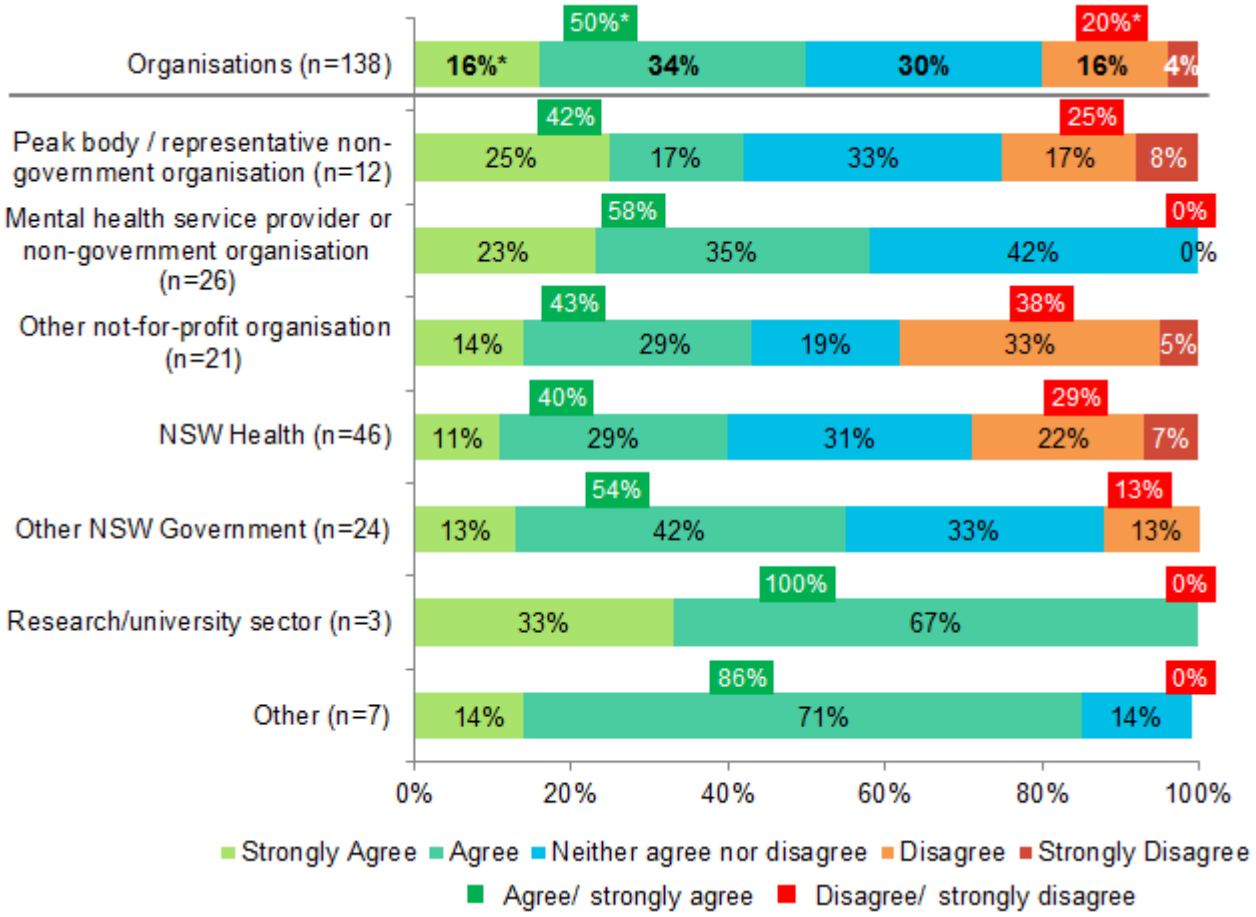
The same pattern emerged, with NSW Government and other organisations being most likely to endorse the work of the Commission (45% and 55% respectively); and individuals with lived experience of mental illness and their carers (36%) and the group of health professionals/other individuals (38%) being least positive.

Figure 95: Level of agreement that the Commission's work has taken into account *the interaction between people who have a mental illness and the criminal justice system,* overall and by high level organisation and individual groupings (n=331)



Within each broad category, any variation was not statistically significant. However, it is worth noting that (within organisations) peak bodies (42%) and other not for profits (43%) indicated the lowest levels of agreement. (See Figure 96.)

Figure 96: Organisations' level of agreement that the Commission's work has taken into account *the interaction between people who have a mental illness and the criminal justice system*, overall and by organisation type (n=138)



Looking at the categories of individual submissions, in Figure 97 to Figure 99, again it was the language other than English speaking Australians who were most positive (57% compared with 37% overall).

Figure 97: Individuals' level of agreement that the Commission's work has taken into account *the interaction between people who have a mental illness and the criminal justice system,* overall and by individual background (n=193)

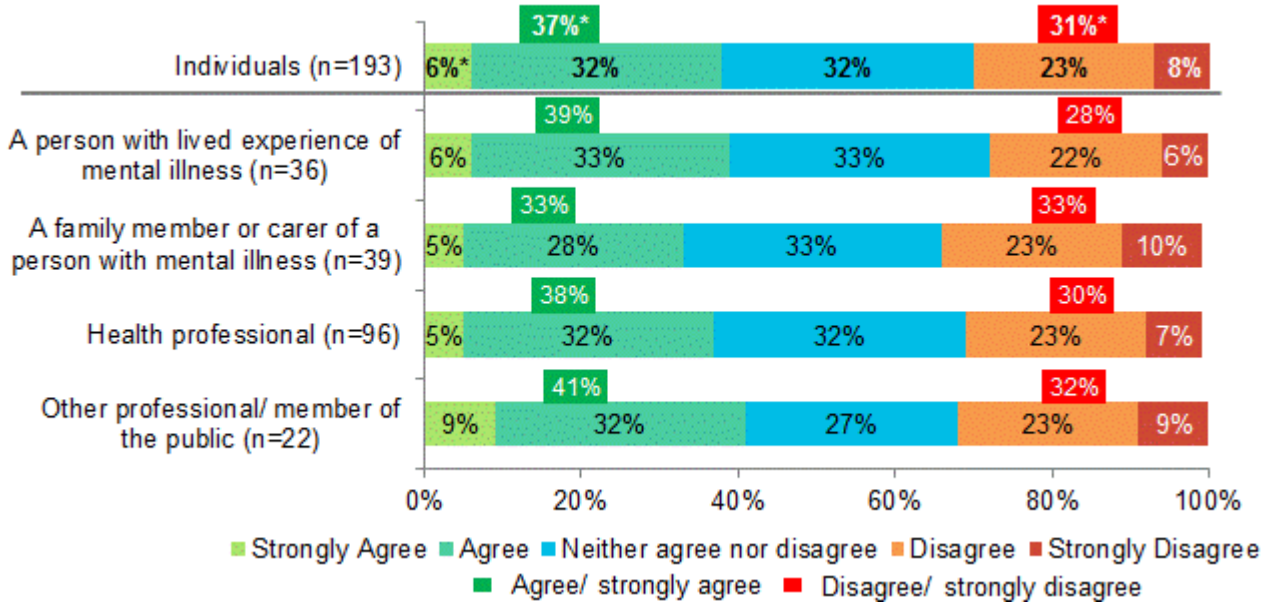



Figure 98: Level of agreement that the Commission's work has taken into account *the interaction between people who have a mental illness and the criminal justice system*, by Aboriginal and Torres Strait Islander origin (n=189)

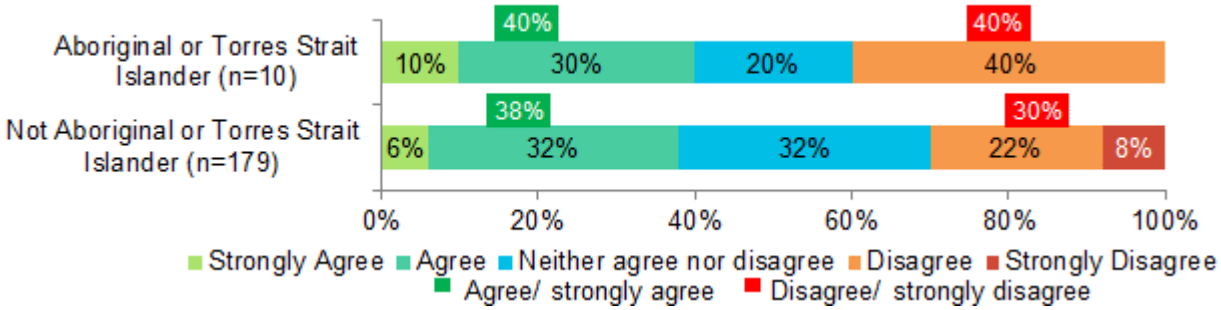
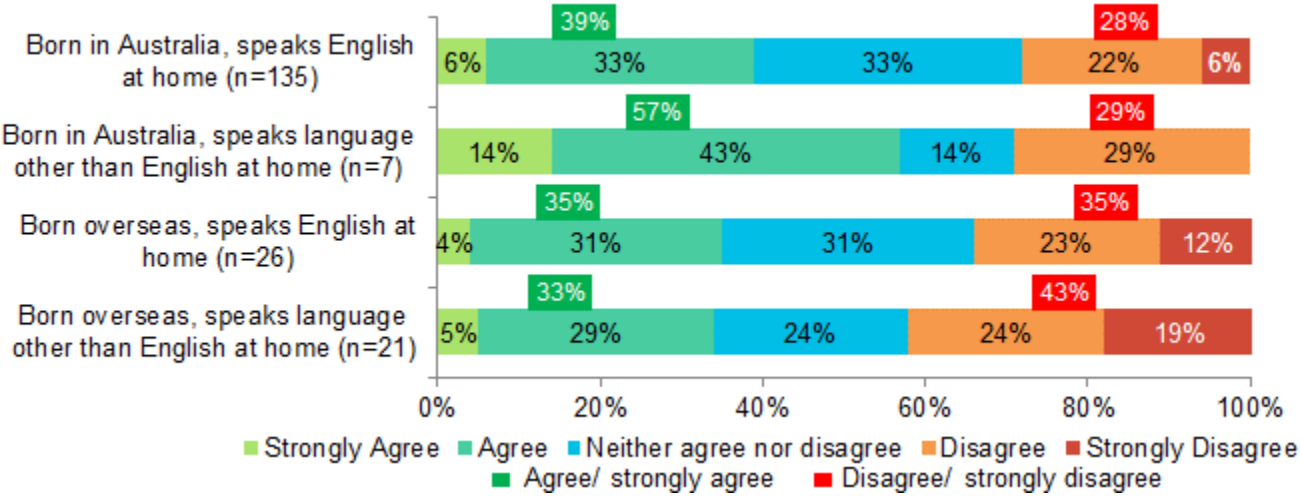
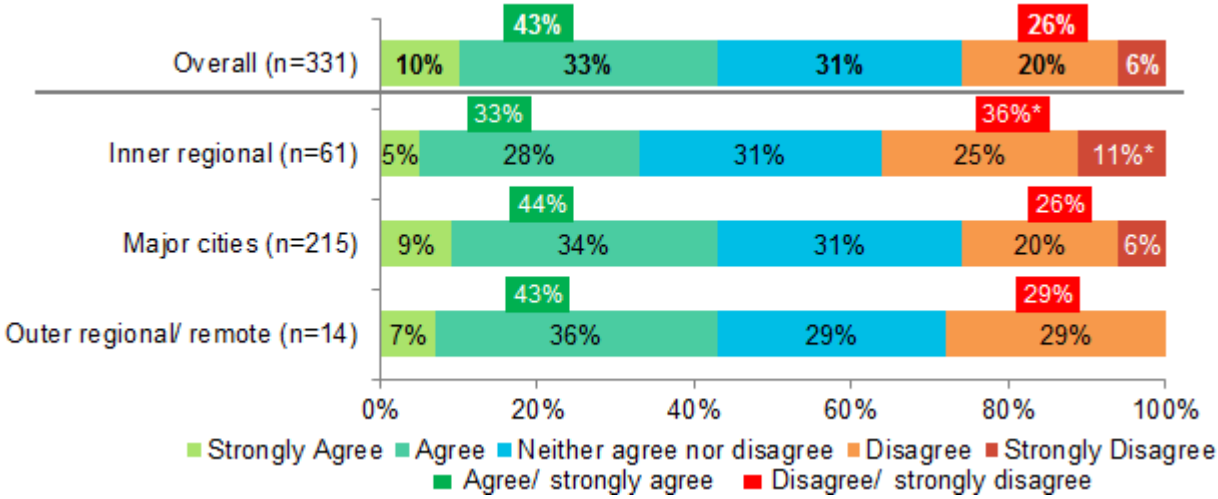


Figure 99: Level of agreement that the Commission's work has taken into account *the interaction between people who have a mental illness and the criminal justice system*, by culturally and linguistically diverse categories (n=189)




The lowest agreement came from inner regional areas (33%); and, overall, organisations were significantly more likely to be positive (50%) than submissions made by individuals (37%).

Figure 100: Level of agreement that the Commission's work has taken into account *the interaction between people who have a mental illness and the criminal justice system,* overall and by remoteness category (n=331)



## 7.4 Different sections of the community

The Act stated that, in exercising its functions, the Commission was *to take into account the particular views and needs of different sections of the community, including Aboriginal communities, culturally and linguistically diverse communities and regional and remote communities*.

In relation to this requirement, the submission questionnaire asked a series of questions around the extent to which the Commission's work was perceived to have taken into account the needs of diverse communities, including Aboriginal people, CALD, and people in regional and remote areas.

Overall levels of agreement hovered around one in two across each of the statements. There was a consistent pattern of lower endorsement among individuals (including those with lived experience of mental illness/carers and health professionals); and higher positivity among NSW Government and other organisations.

Just over half (53%) of all submissions agreed/strongly agreed with the statement that the Commission's work takes into account the needs of Aboriginal Australians. Aboriginal respondents were less likely to agree with this statement (36% compared with 48%); although again this was non-significant.

Just under a half (48%) of submissions felt that the needs of CALD communities are met by the Commission's work. Those born overseas were the least positive in this regard, irrespective of whether they spoke English or a language other than English at home (31% and 22% respectively).

Agreement with success in meeting the needs of regional and remote communities was slightly lower overall (47%) than the communities discussed above; and was notably lower among those from inner regional (36%) and remote (31%) communities themselves, compared with city dwellers (51%).

The results for these questions, by the various segments, can be seen in Figure 101 through to Figure 106.

Figure 101: Level of agreement that the Commission's work has taken into account the needs of *Aboriginal people and communities, culturally and linguistically diverse communities, and regional and remote communities*, overall and by high level organisation and individual groupings (n=349)

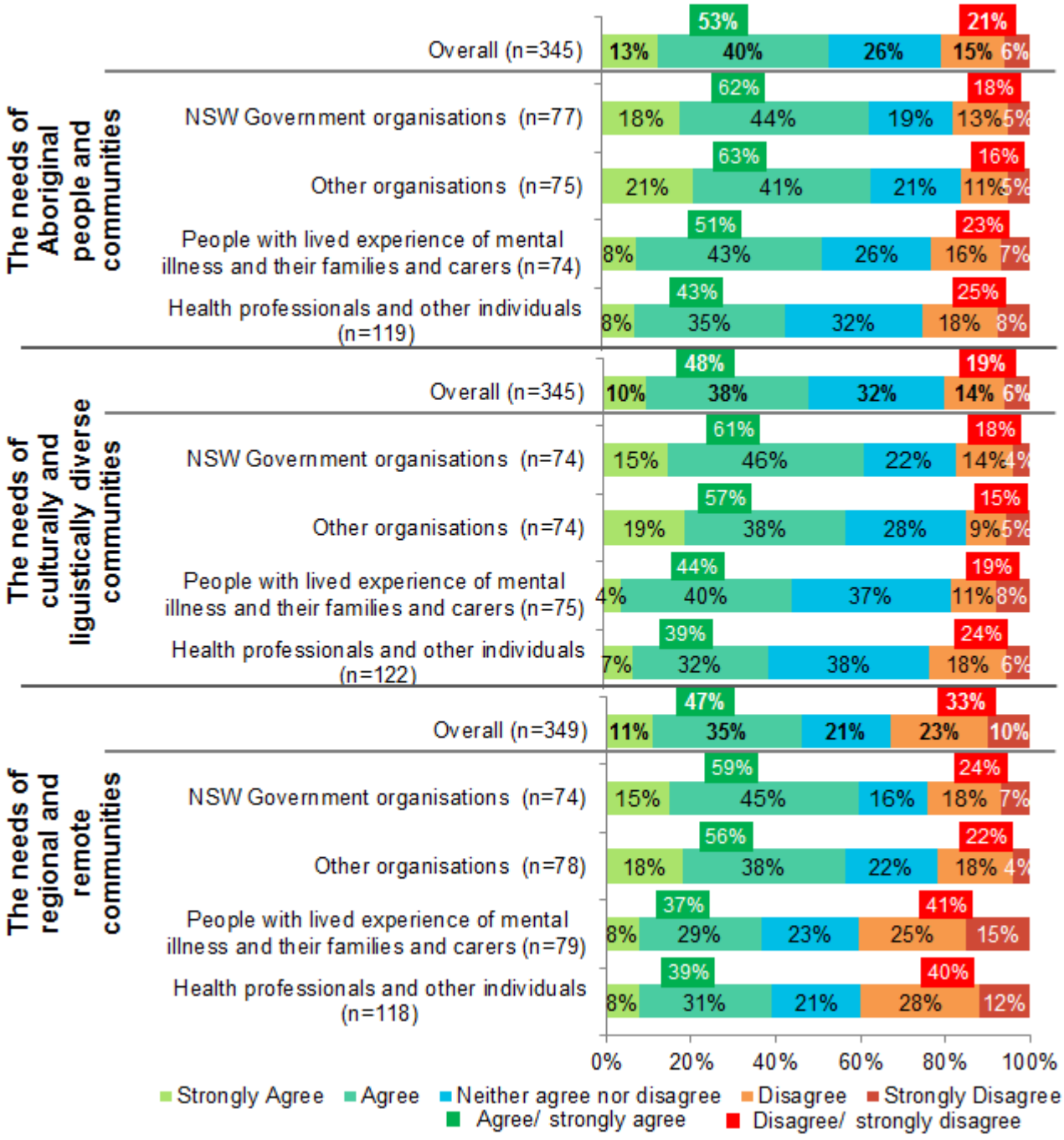


Figure 102: Organisations' level of agreement that the Commission's work has taken into account the needs of *Aboriginal people and communities, culturally and linguistically diverse communities, and regional and remote communities*, overall and by organisation type (n=152)

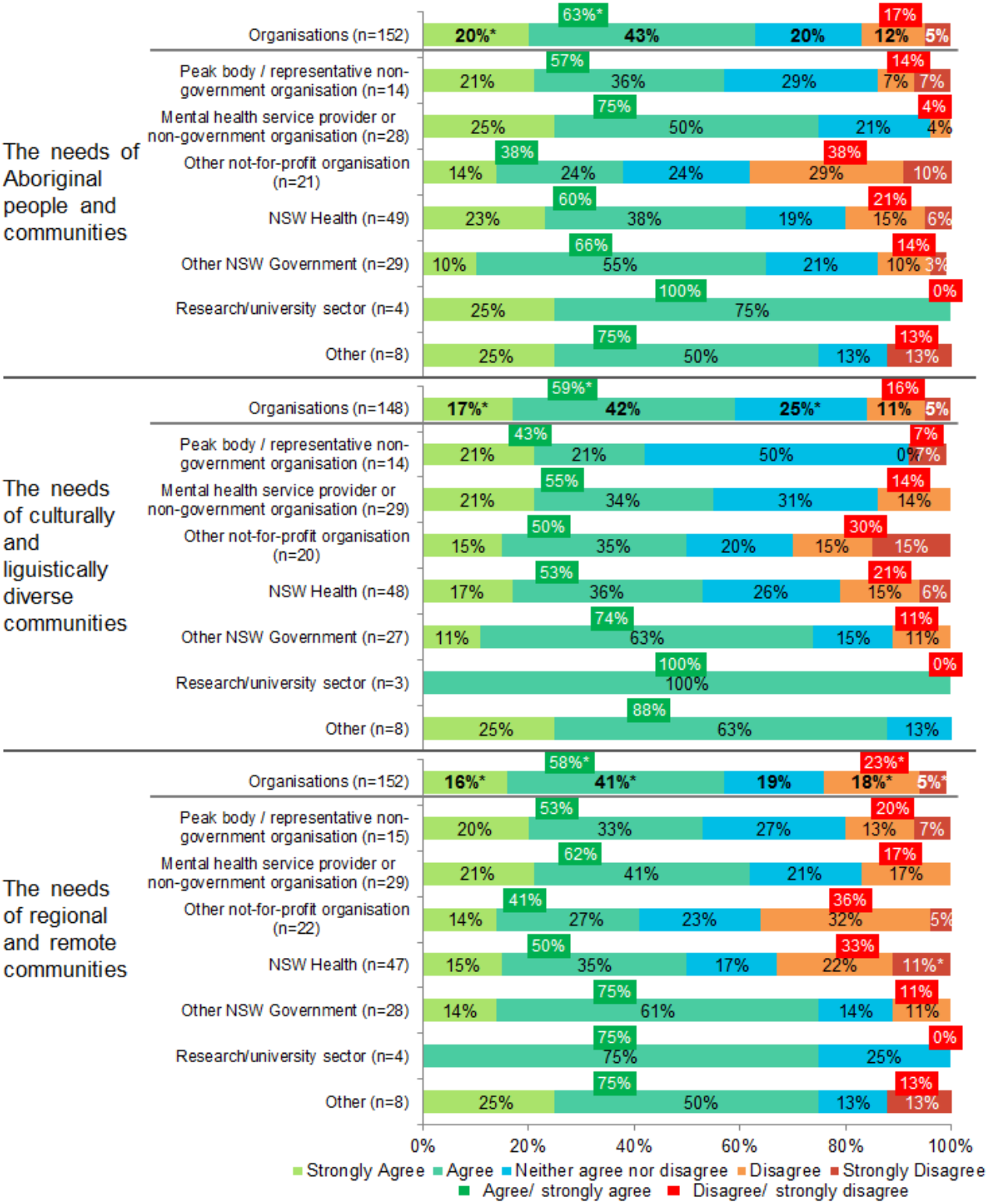


Figure 103: Individuals' level of agreement that the Commission's work has taken into account the needs of *Aboriginal people and communities, culturally and linguistically diverse communities, and regional and remote communities*, overall and by individual background (n=197)

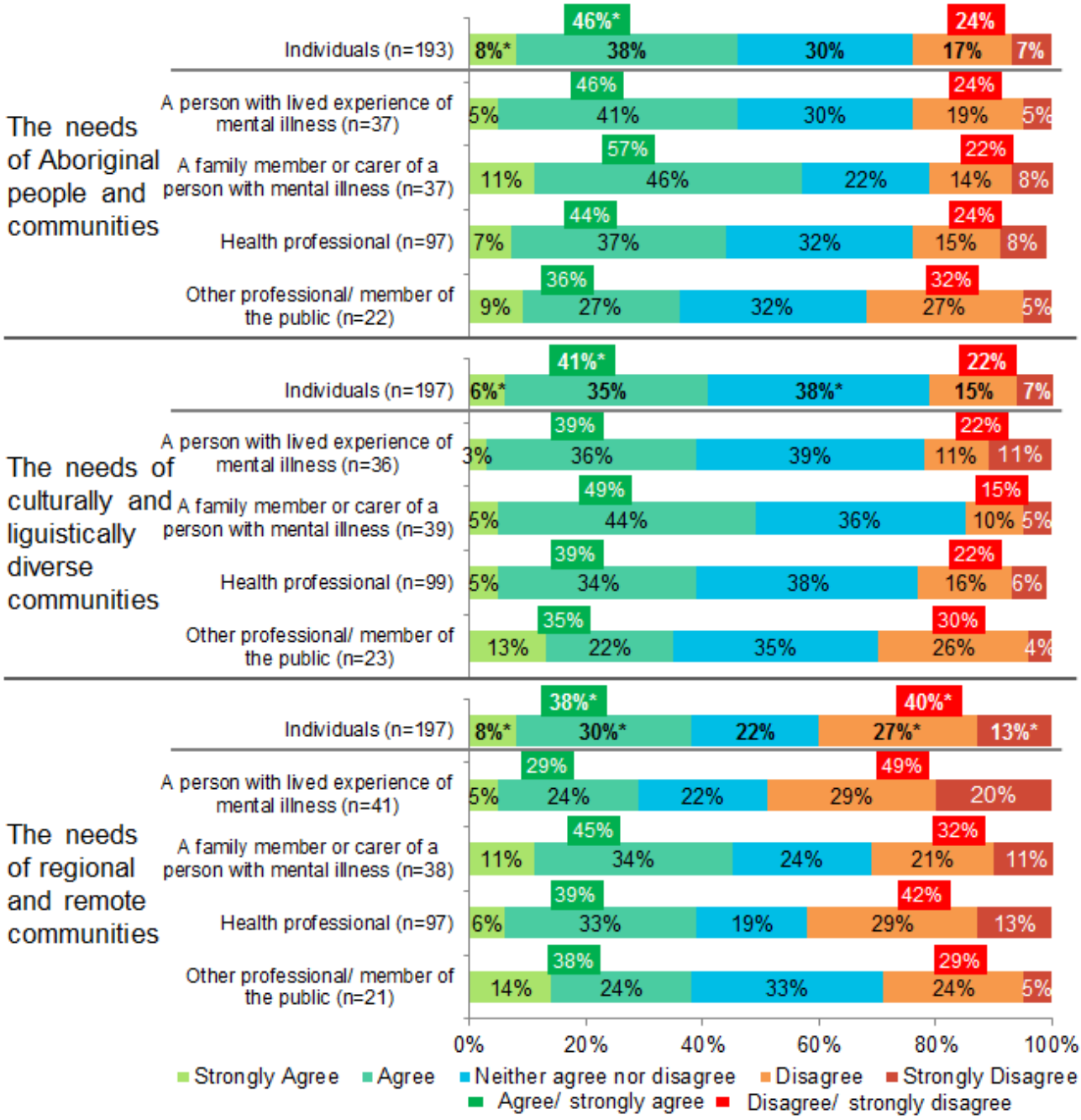


Figure 104: Level of agreement that the Commission's work has taken into account the needs of *Aboriginal people and communities, culturally and linguistically diverse communities, and regional and remote communities*, by Aboriginal and Torres Strait Islander origin (n=193)

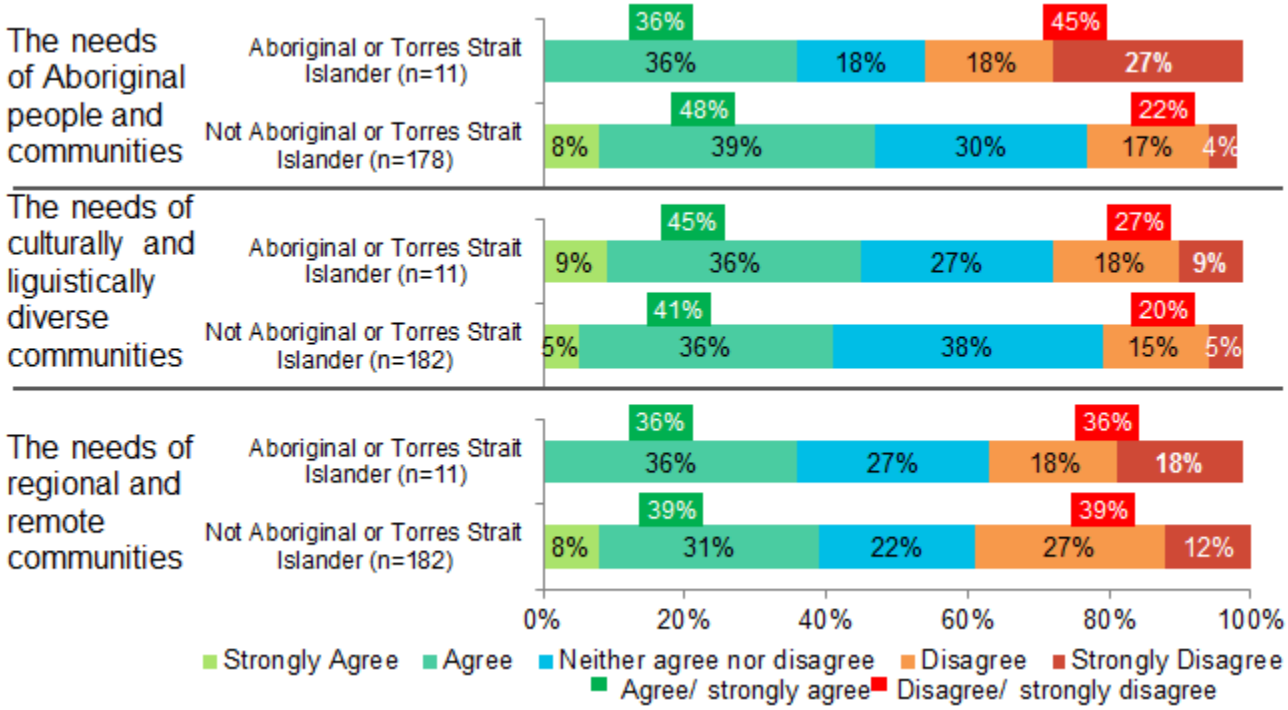


Figure 105: Level of agreement that the Commission's work has taken into account the needs of *Aboriginal people and communities, culturally and linguistically diverse communities, and regional and remote communities*, by culturally and linguistically diverse categories (n=193)

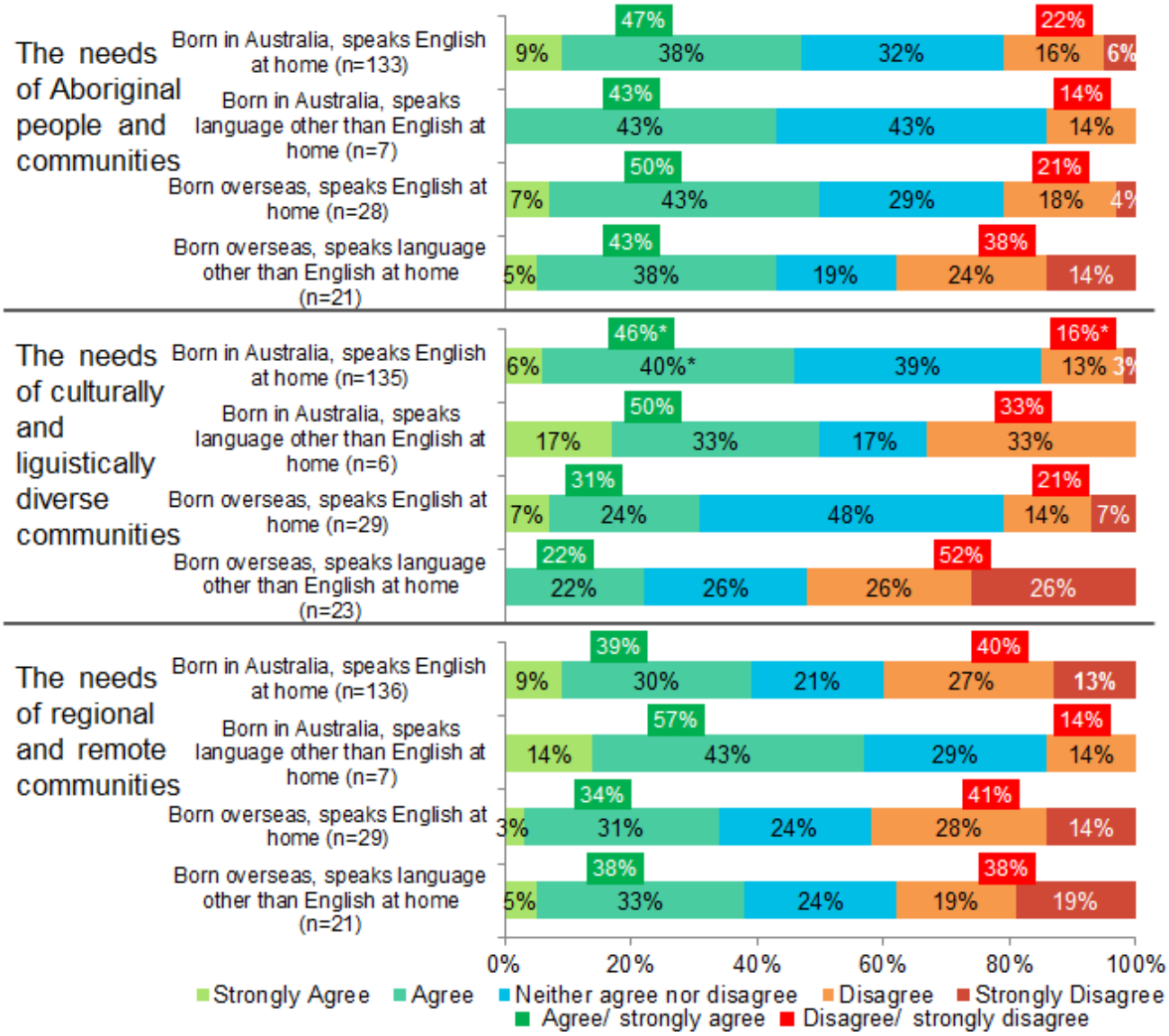
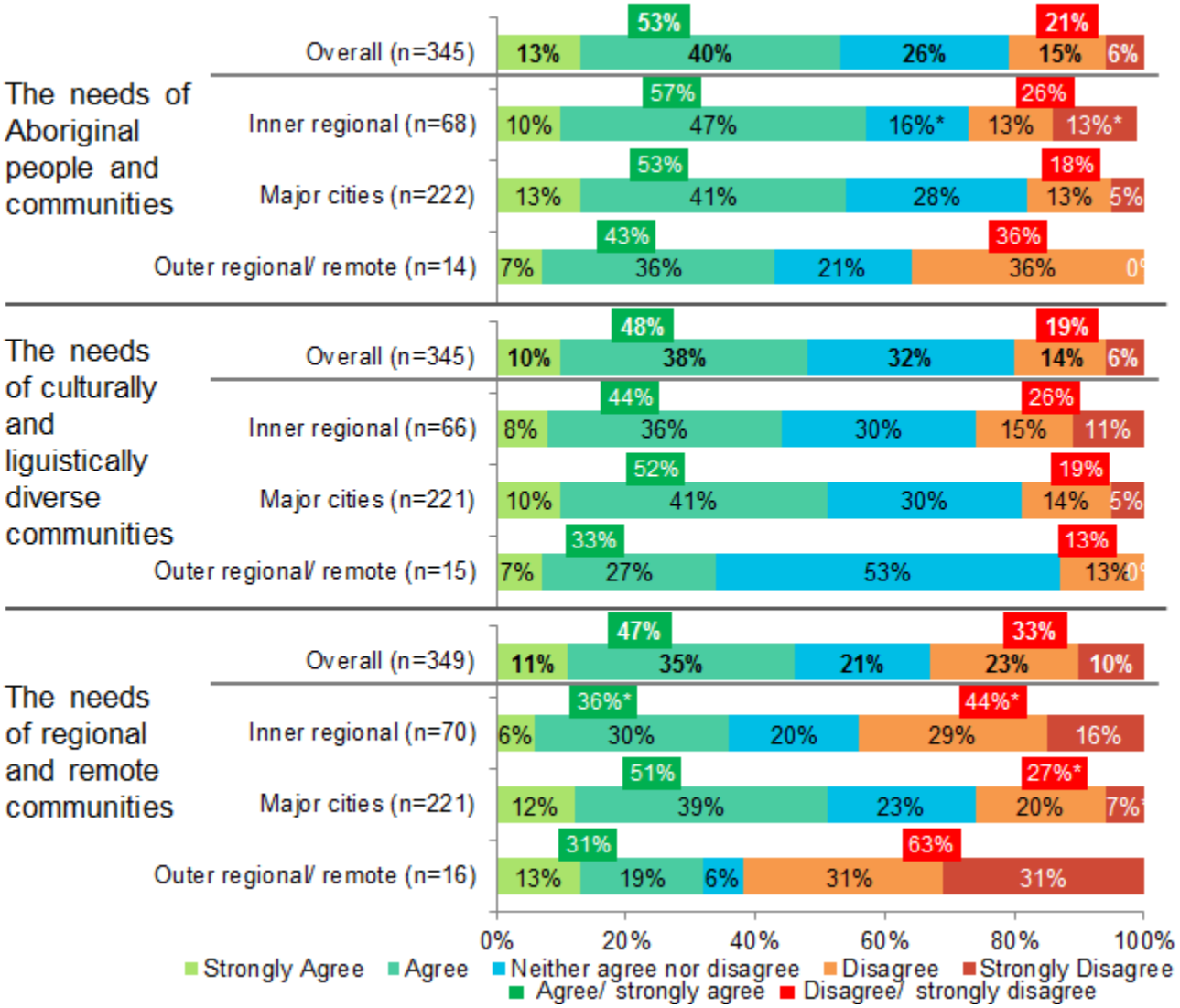


Figure 106: Level of agreement that the Commission's work has taken into account the needs of *Aboriginal people and communities, culturally and linguistically diverse communities, and regional and remote communities*, overall and by remoteness category (n=349)



## 7.5 Engagement and consultation

The Act also required the Commission to *engage and consult with*:

- *people who have a mental illness and their families and carers*
- *the government and non-government sectors*
- *the whole community.*

### 7.5.1 People who have a mental illness and their families and carers

Around one in two (52%) submissions agreed/strongly agreed that the Commission's work had effectively engaged and consulted with people with a mental illness. Three in ten (29%) disagreed/ strongly disagreed with this statement, and one fifth (19%) were neutral.

People who had experienced mental illness themselves and their carers were markedly less likely to agree that the Commission had effectively engaged and consulted with them (35%). Looking separately at individuals and carers showed that individuals were less likely to agree/ strongly agree that they had been engaged with (29%) than their carers/families (41%).

A similar proportion overall (55%) endorsed the Commission's work in engaging with the families and carers of people with a mental illness. Again, positivity was lower among the target segment itself (40%) than among NSW Government (67%) and other organisations (65%). This time, the pattern within the individuals category was reversed, with 37% of carers/family members feeling that they had been effectively consulted, compared with 44% of those with lived experience of mental illness.

The findings for these engagement and consultation assessments are given in Figure 107 through to Figure 112.

Figure 107: Level of agreement that the Commission has effectively engaged and consulted with *people who have a mental illness, and families and carers of people with a lived experience of mental illness*, overall and by high level organisation and individual groupings (n=365)

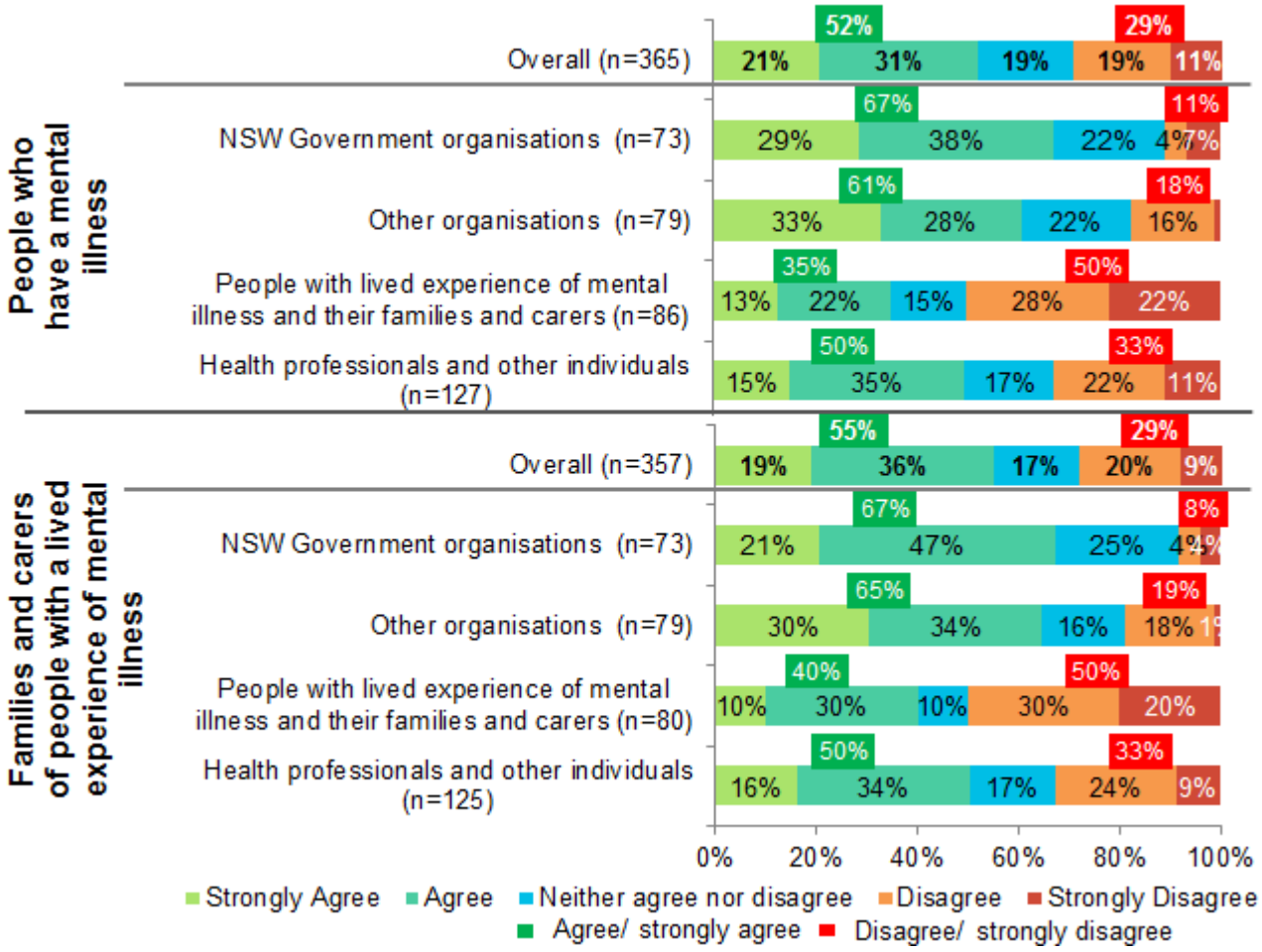


Figure 108: Organisations' level of agreement that the Commission has effectively engaged and consulted with *people who have a mental illness, and families and carers of people with a lived experience of mental illness*, overall and by organisation type (n=152)

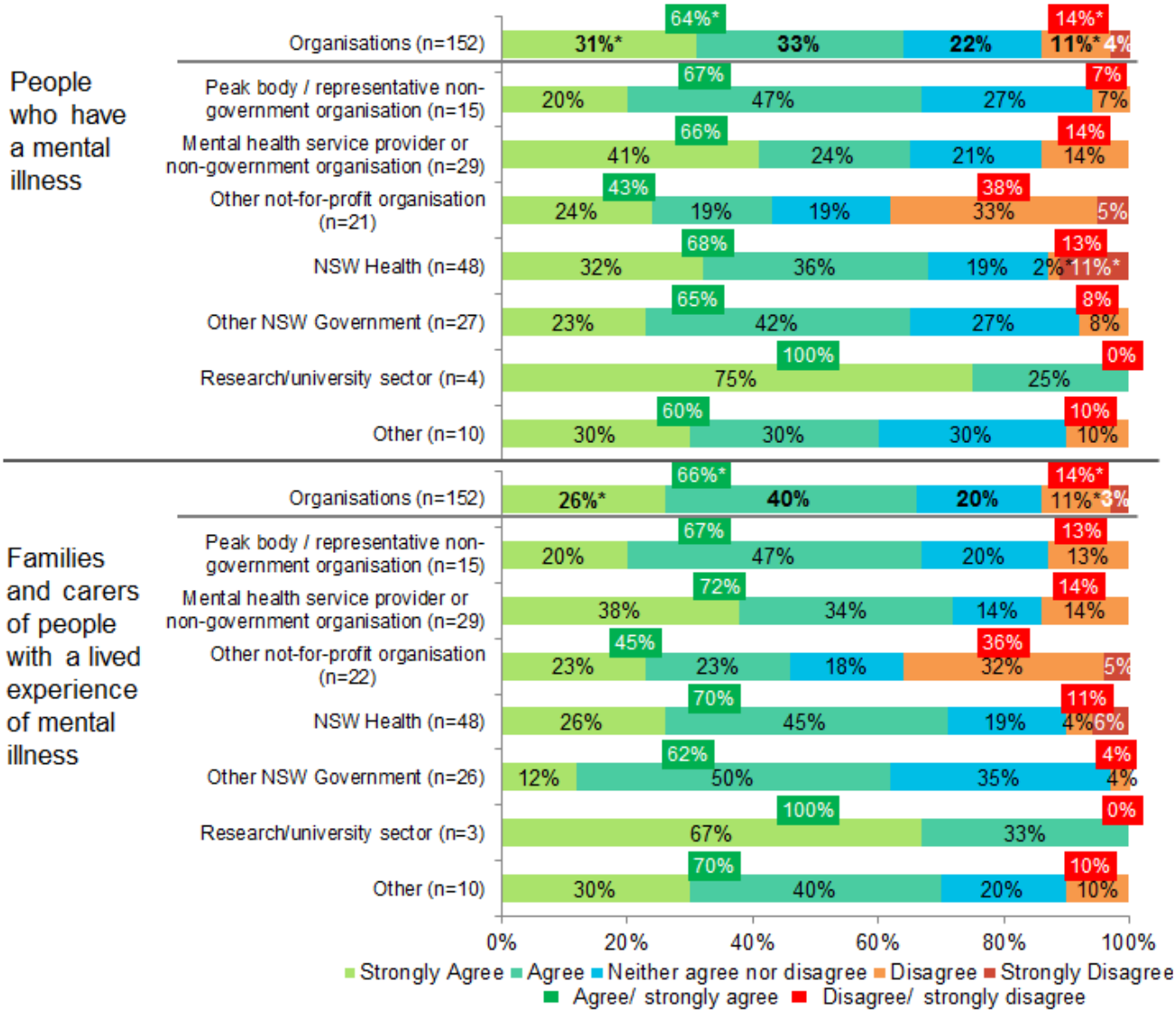


Figure 109: Individuals' level of agreement that the Commission has effectively engaged and consulted with *people who have a mental illness, and families and carers of people with a lived experience of mental illness*, overall and by individual background (n=213)

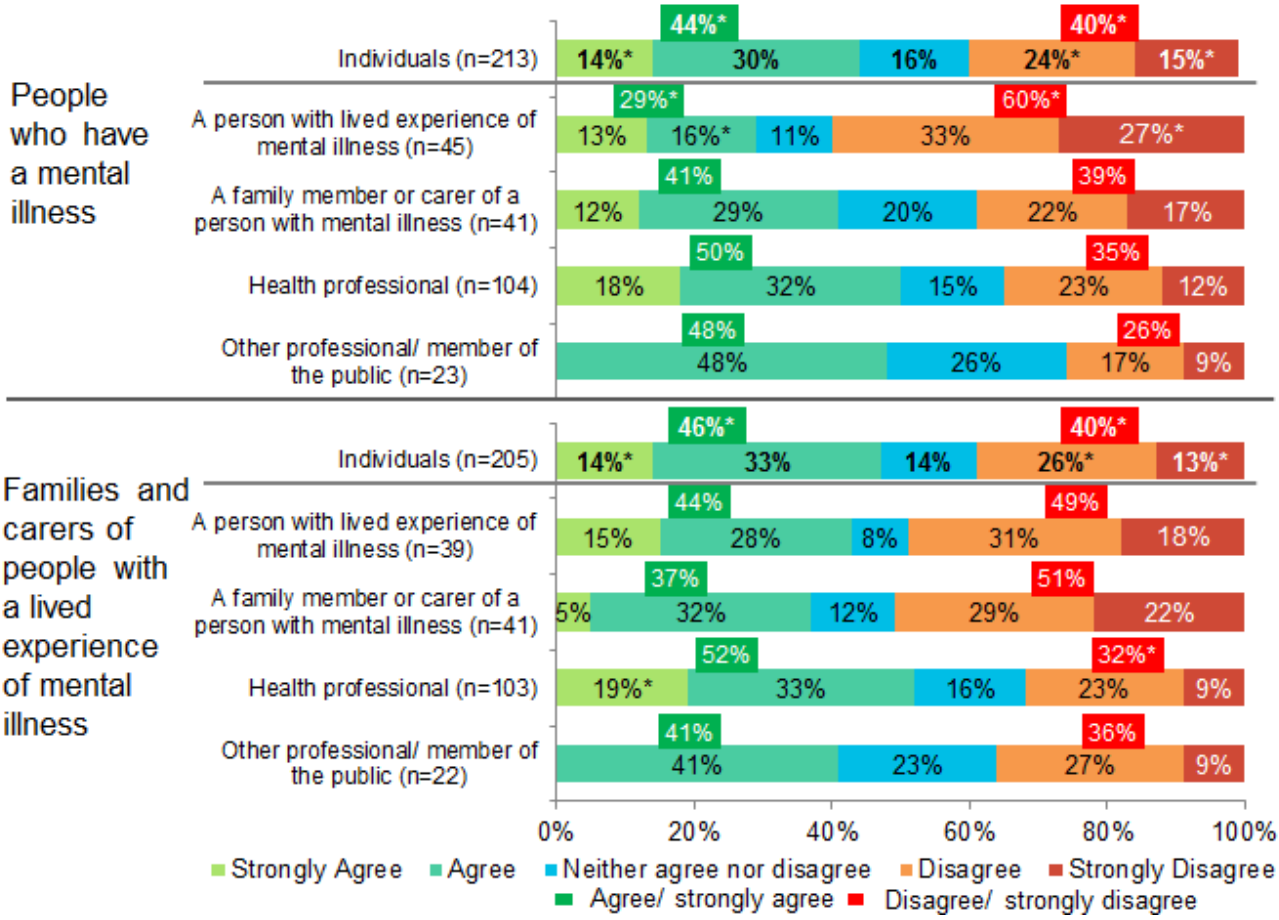


Figure 110: Level of agreement that the Commission has effectively engaged and consulted with *people who have a mental illness, and families and carers of people with a lived experience of mental illness*, by Aboriginal and Torres Strait Islander origin (n=209)

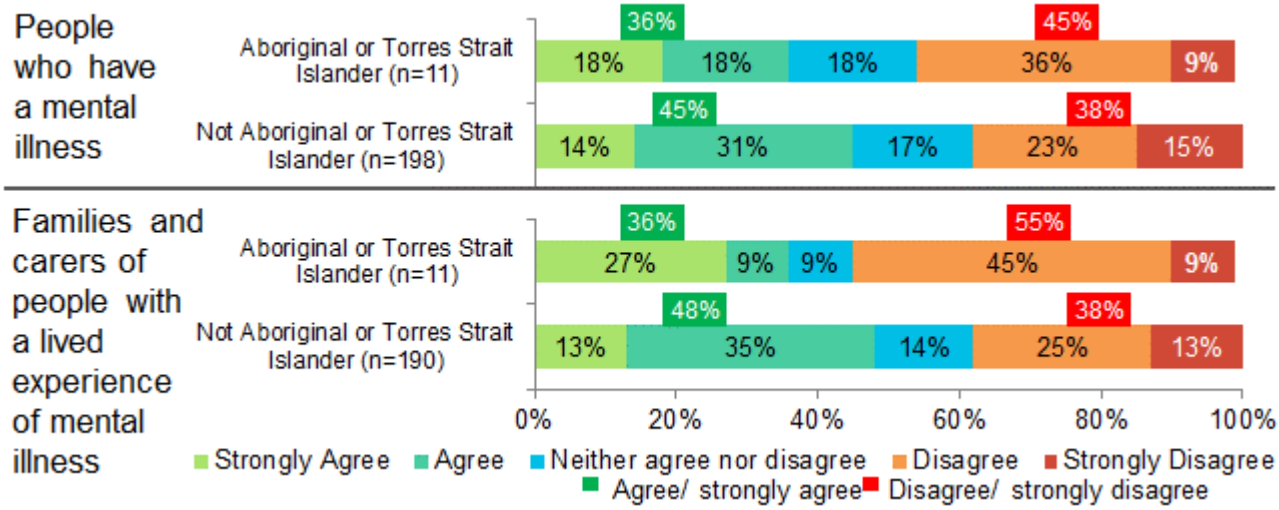


Figure 111: Level of agreement that the Commission has effectively engaged and consulted with *people who have a mental illness, and families and carers of people with a lived experience of mental illness,* by culturally and linguistically diverse categories (n=210)

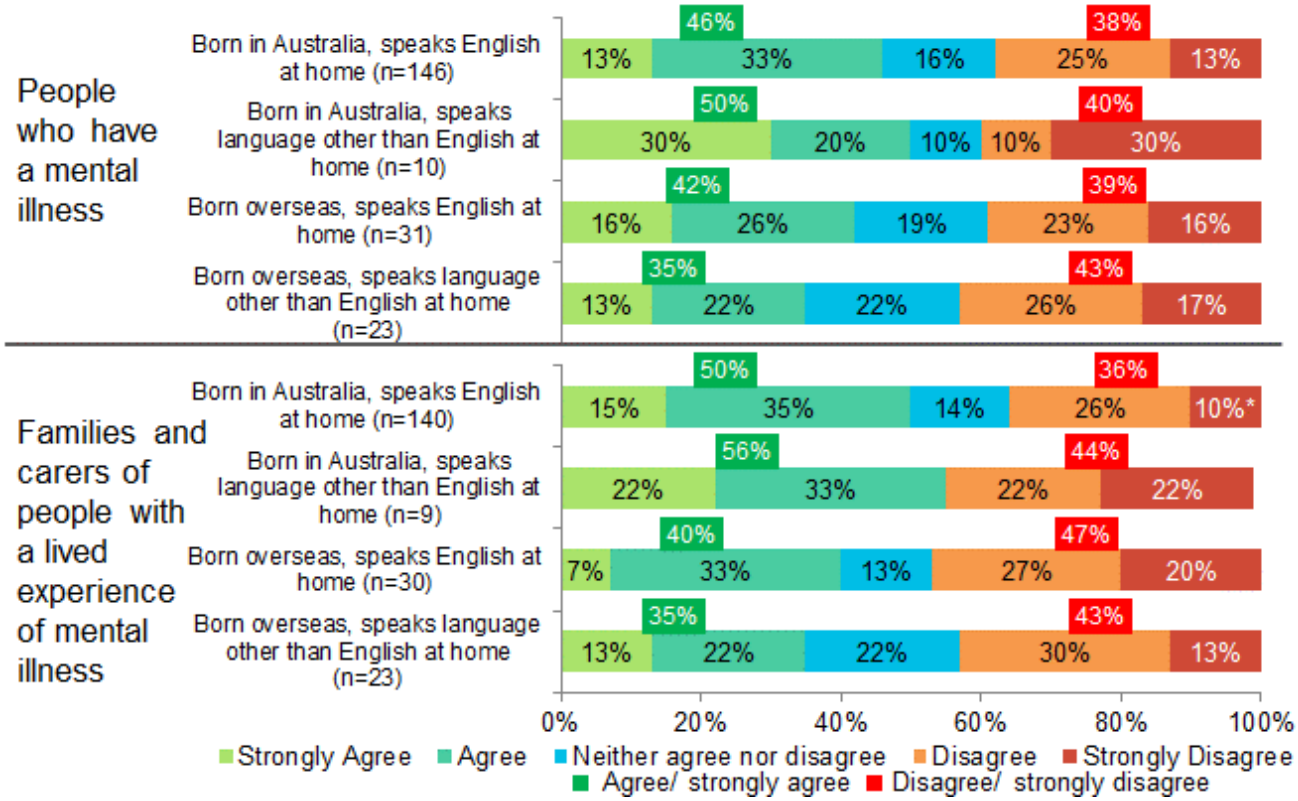
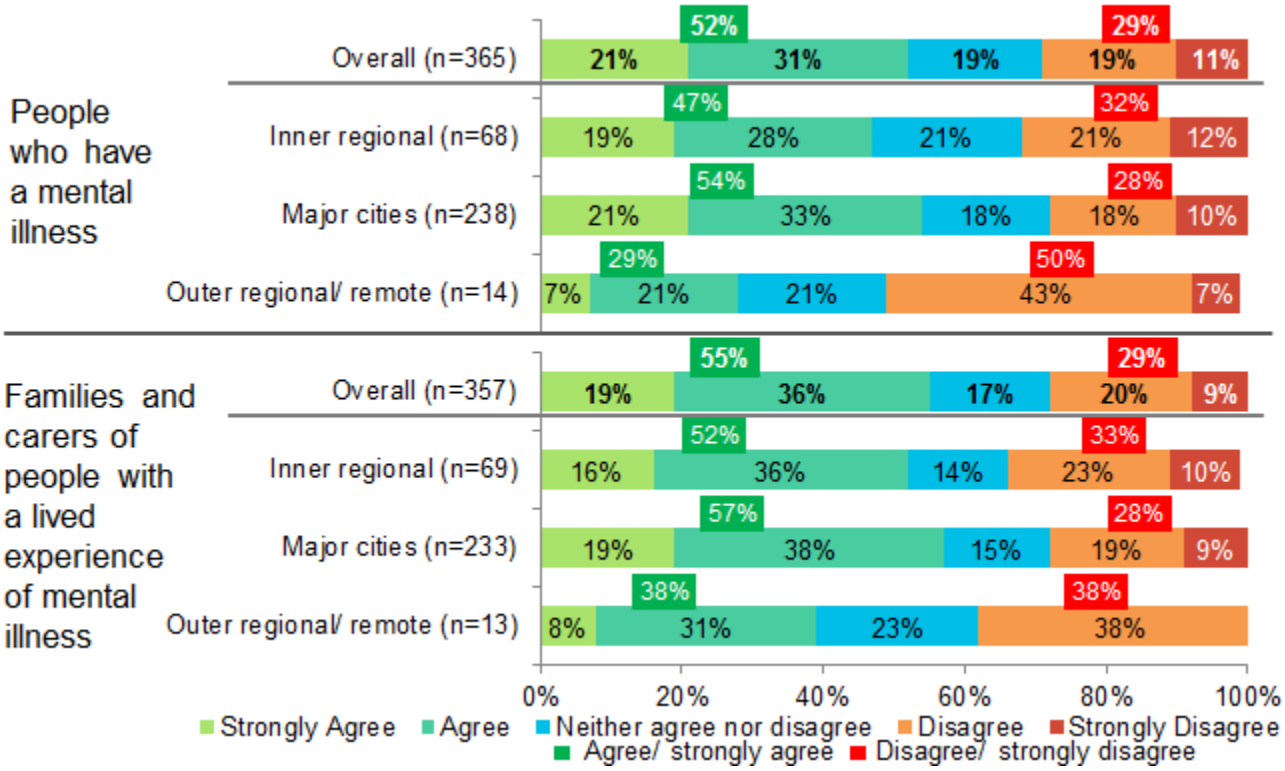


Figure 112: Level of agreement that the Commission has effectively engaged and consulted with *people who have a mental illness, and families and carers of people with a lived experience of mental illness*, overall and by remoteness category (n=365)

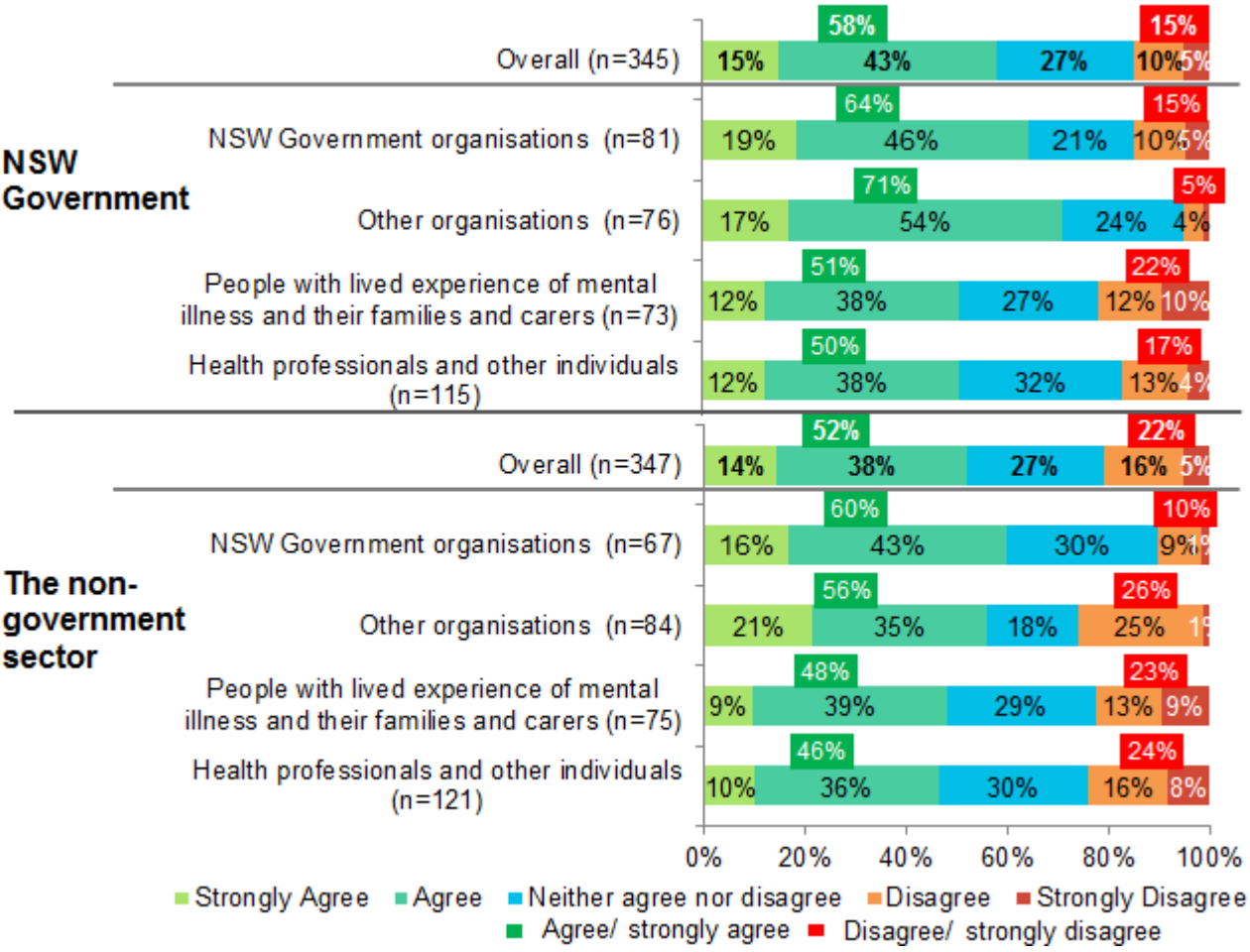


## 7.5.2 The government and non-government sectors

The consultation also covered aspects of the Commission's engagement with the government and non-government sectors in NSW. The majority of submissions agreed/strongly agreed that the Commission had engaged effectively with both the government (58%) and the non-government sectors (52%).

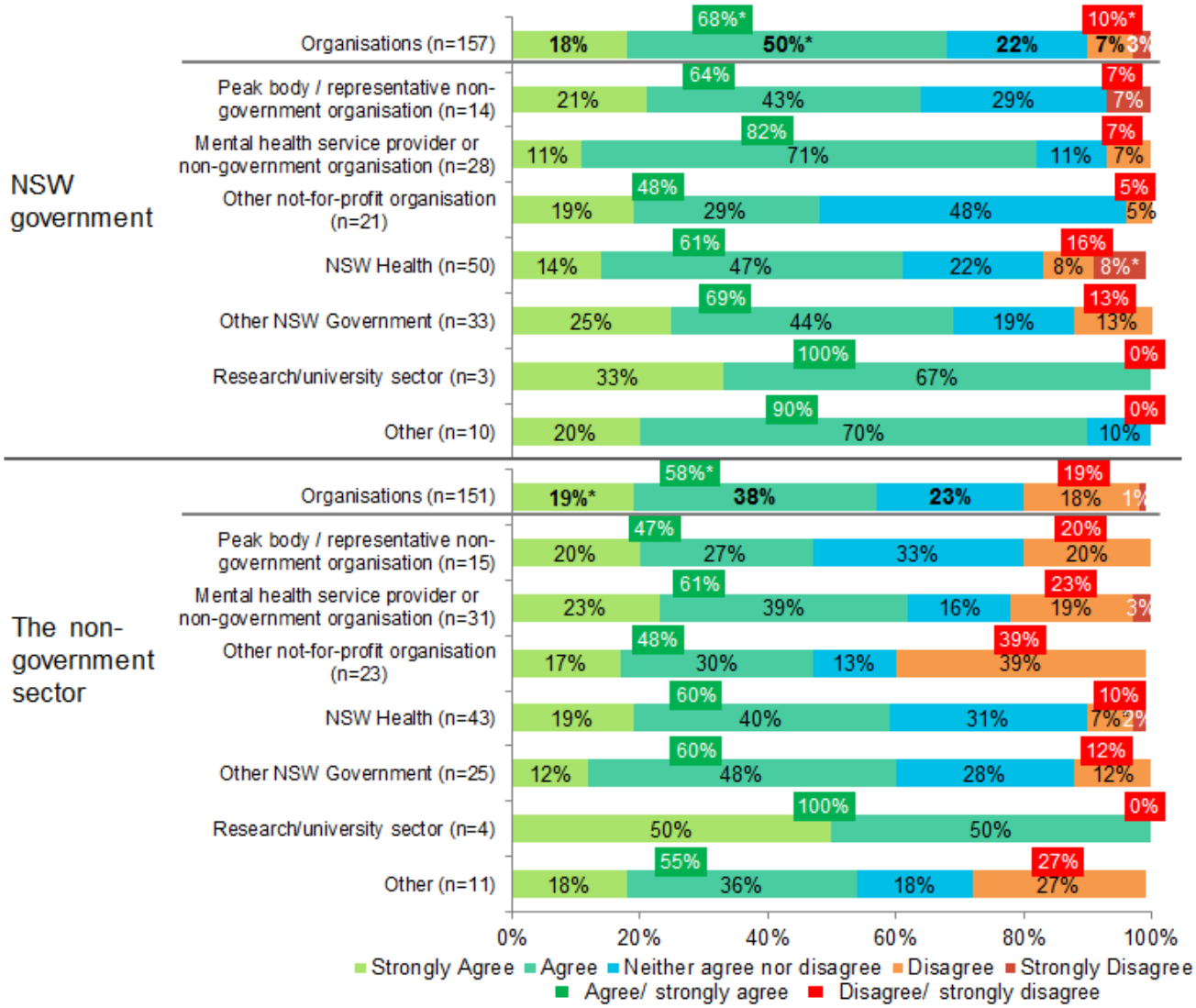
Levels of endorsement were high among the target segments themselves, with 64% of NSW Government organisations agreeing/strongly agreeing that they had been effectively engaged with; and 56% of non-NSW Government organisations endorsing their relevant statement.

Figure 113: Level of agreement that the Commission has effectively engaged and consulted with *NSW Government, and the non-government sector*, overall and by high level organisation and individual groupings (n=347)



Within organisations, the relevant government agencies were positive about their level of engagement, with 61% of NSW Health and 69% of 'other' NSW government submissions agreeing/ strongly agreeing with the statement. Their results for non-government sector engagement were both 60%. While the peak bodies and other NGOs agreed that the Commission effectively engaged with the government sector (64%) they were notably less likely to believe that their own organisations (non-government) were effectively consulted (47%).

Figure 114: Organisations' level of agreement that the Commission has effectively engaged and consulted with *NSW Government, and the non-government sector*, overall and by organisation type (n=157)



The online consultation results from the various individual and remoteness category segments on the Commission's effectiveness in engaging and consulting with NSW Government and the non-government sector are shown in Figure 115 to Figure 118Figure 117.

Figure 115: Individuals' level of agreement that the Commission has effectively engaged and consulted with *NSW Government, and the non-government sector,* overall and by individual background (n=196)

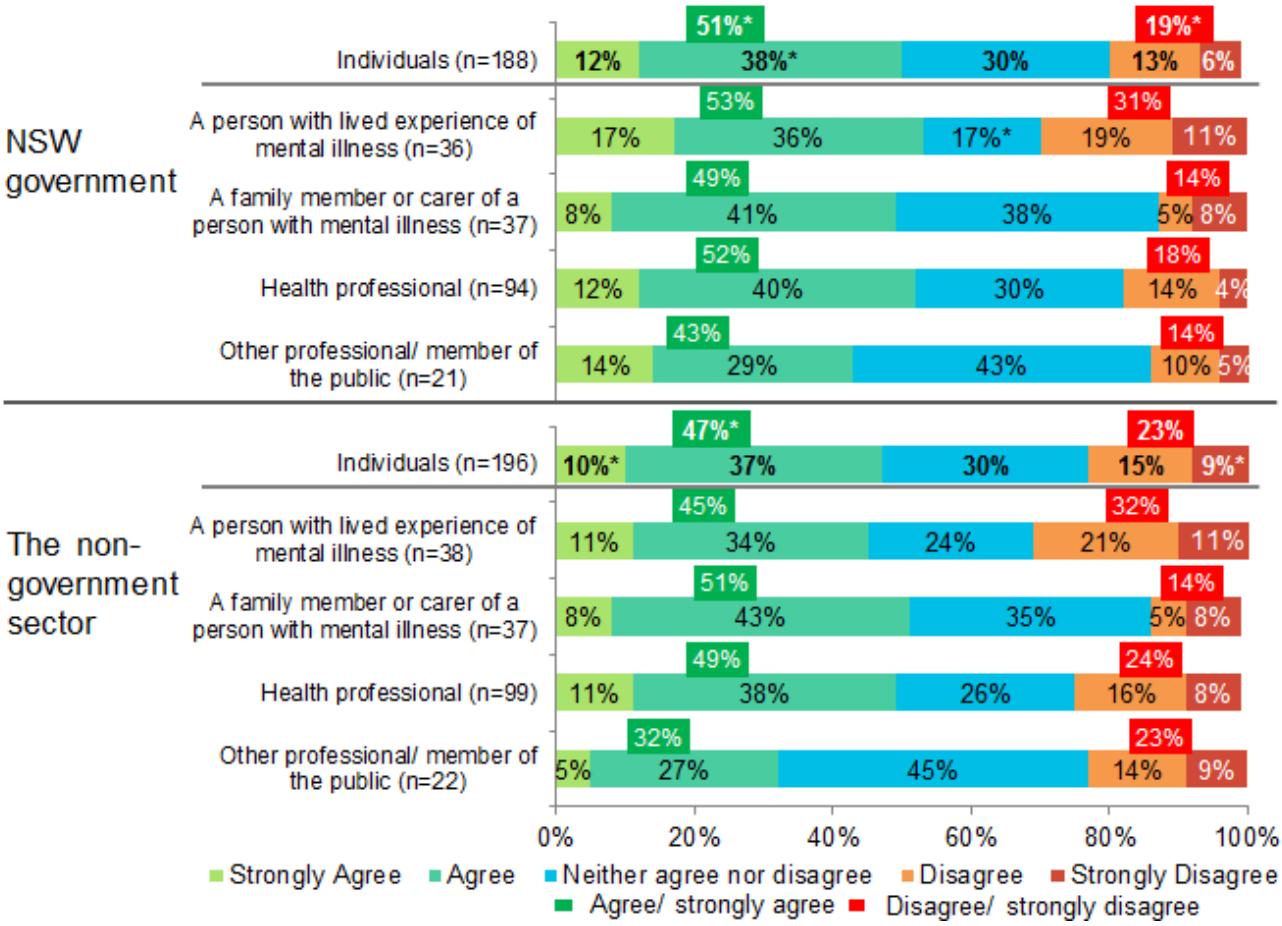


Figure 116: Level of agreement that the Commission has effectively engaged and consulted with *NSW Government, and the non-government sector*, by Aboriginal and Torres Strait Islander origin (n=193)

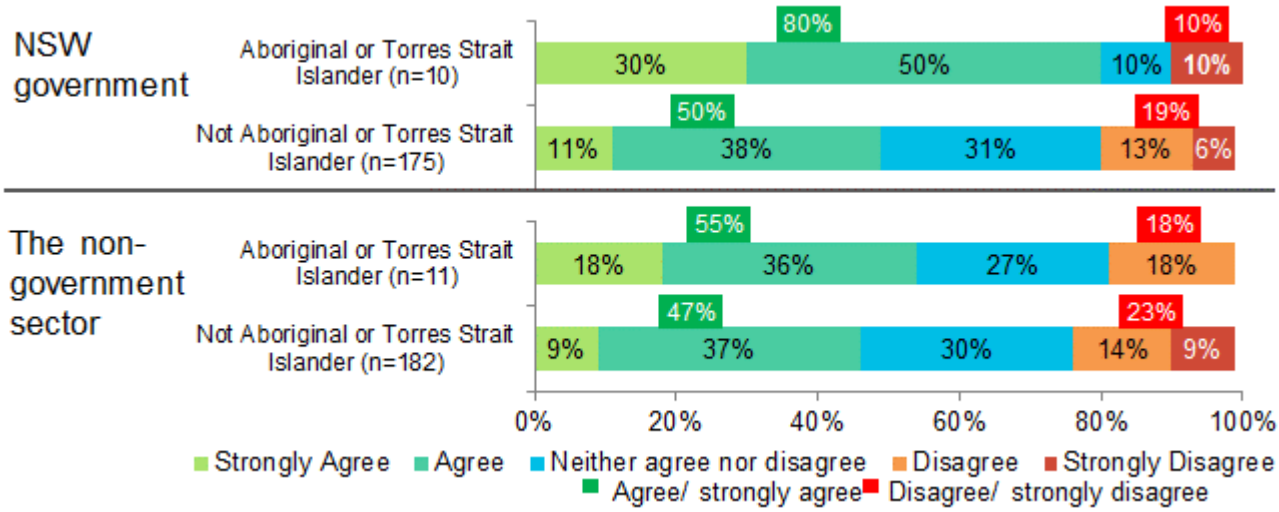



Figure 117: Level of agreement that the Commission has effectively engaged and consulted with *NSW Government, and the non-government sector*, by culturally and linguistically diverse categories (n=194)

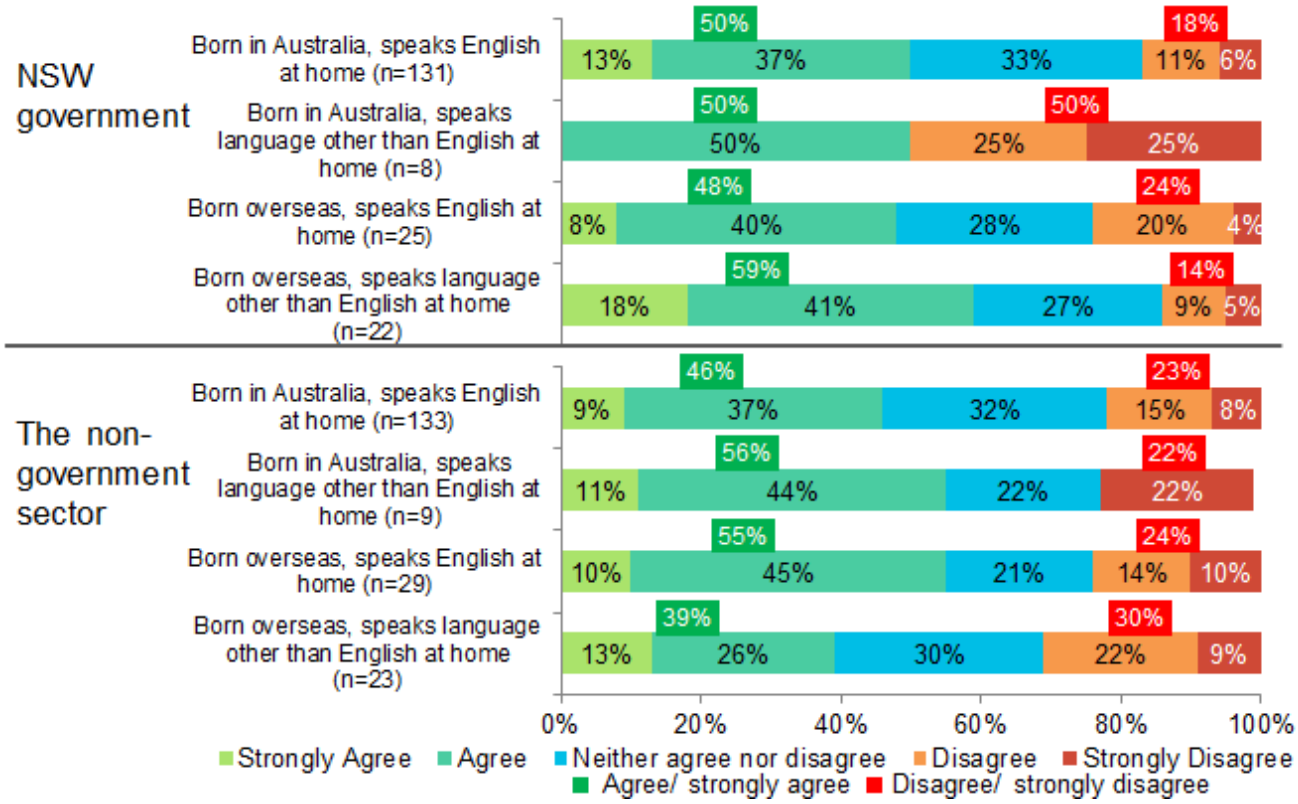
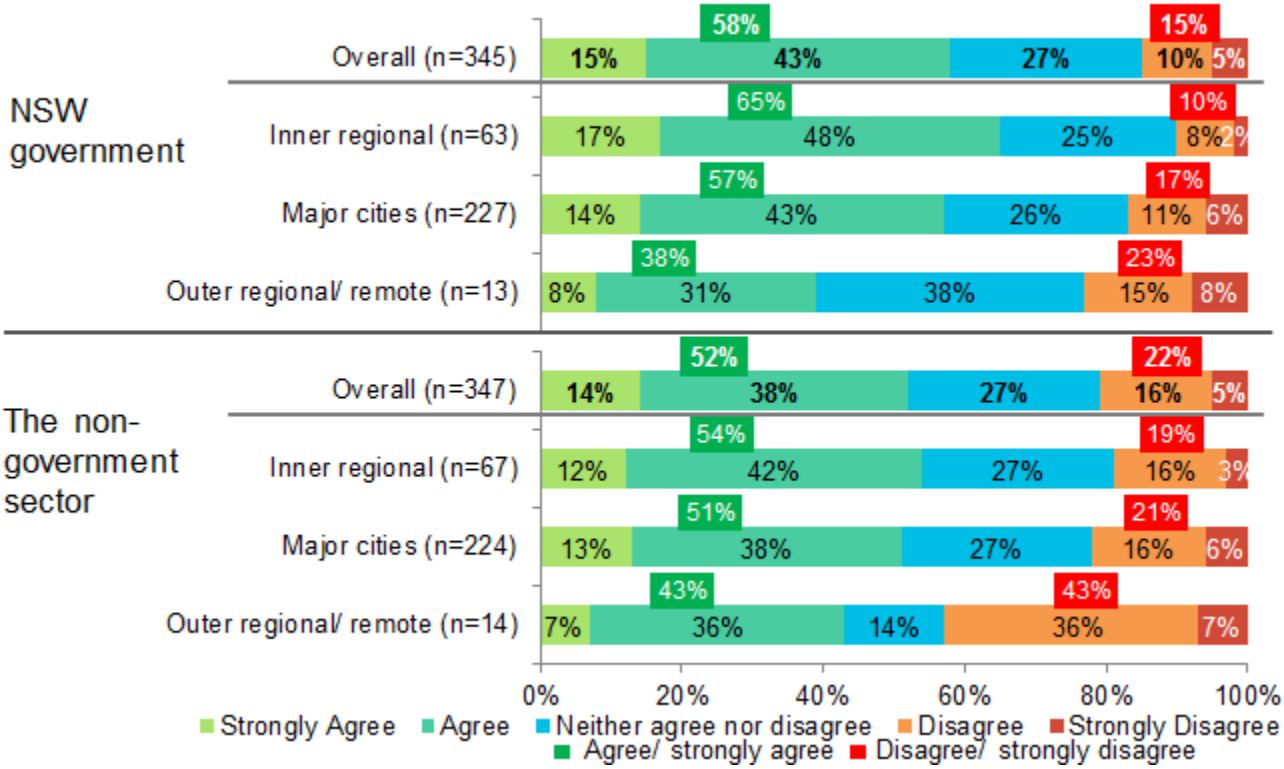


Figure 118: Level of agreement that the Commission has effectively engaged and consulted with *NSW Government, and the non-government sector*, overall and by remoteness category (n=347)

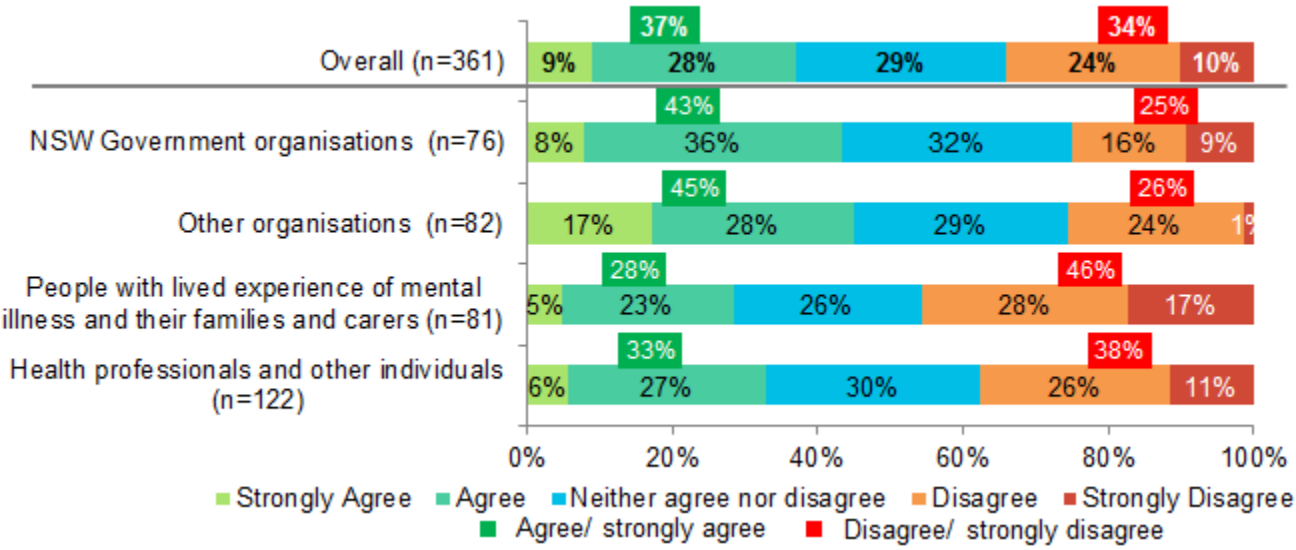


## 7.5.3 The whole community

Having explored the perceived success of the Commission in engaging with specific stakeholders, the consultation asked how successful their work had been in engaging with the whole community.

Just over a third (37%) of submissions felt that the Commission had been successful in this respect. Submissions from individuals within the community were less likely to agree with this statement than those representing NSW Government or other organisations.

Figure 119: Level of agreement that the Commission has effectively engaged and consulted with *the whole community,* overall and by high level organisation and individual groupings (n=361)




Yet again organisations were significantly more positive (44%) than individuals (31%).

See Figure 120 to Figure 124 for these results.

Figure 120: Organisations' level of agreement that the Commission has effectively engaged and consulted with *the whole community*, overall and by organisation type (n=158)

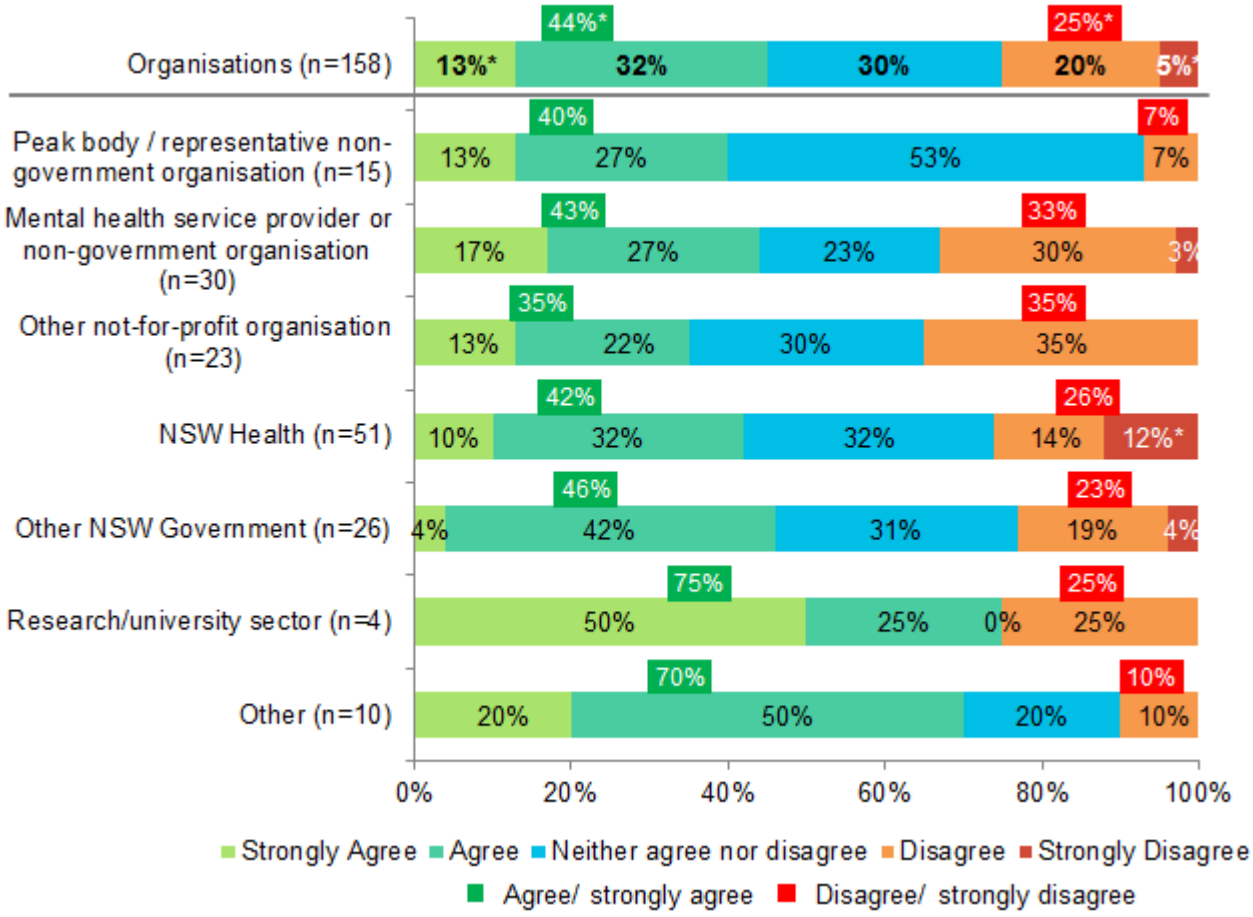


Figure 121: Individuals' level of agreement that the Commission has effectively engaged and consulted with *the whole community*, overall and by individual background (n=203)

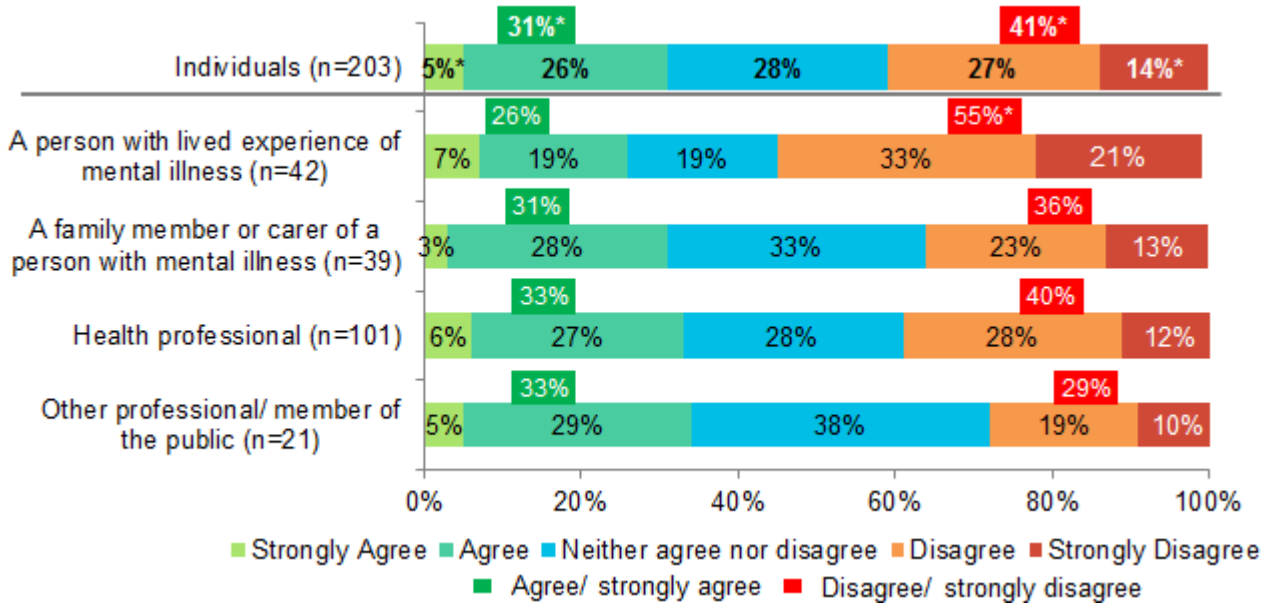



Figure 122: Level of agreement that the Commission has effectively engaged and consulted with *the whole community*, by Aboriginal and Torres Strait Islander origin (n=200)

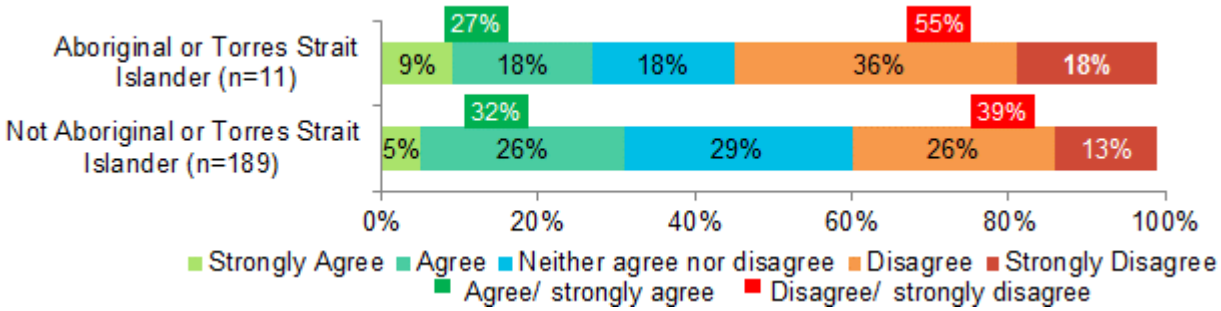


Figure 123: Level of agreement that the Commission has effectively engaged and consulted with *the whole community*, by culturally and linguistically diverse categories (n=201)

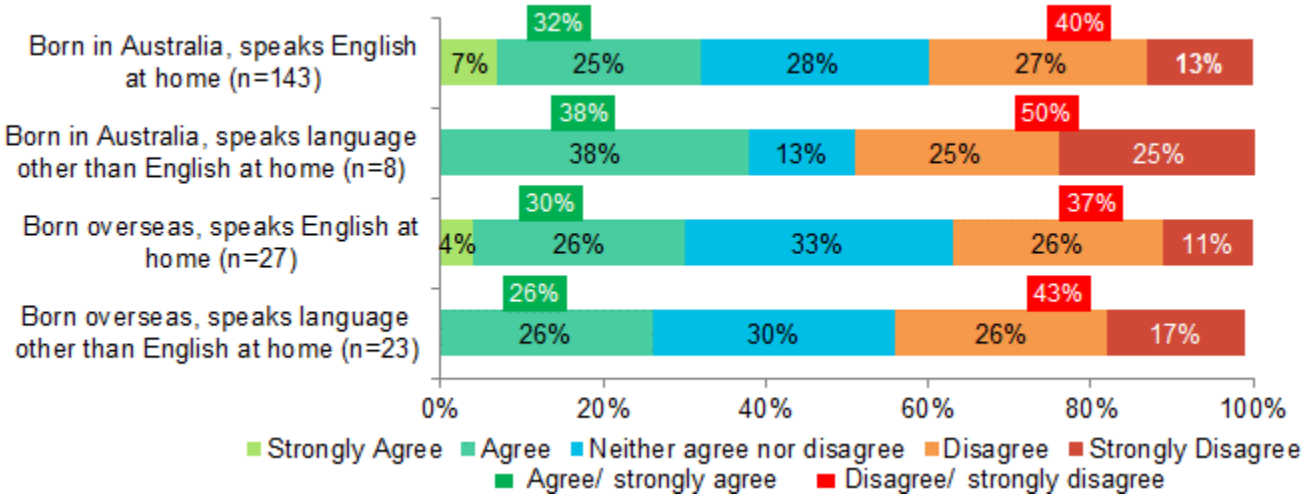
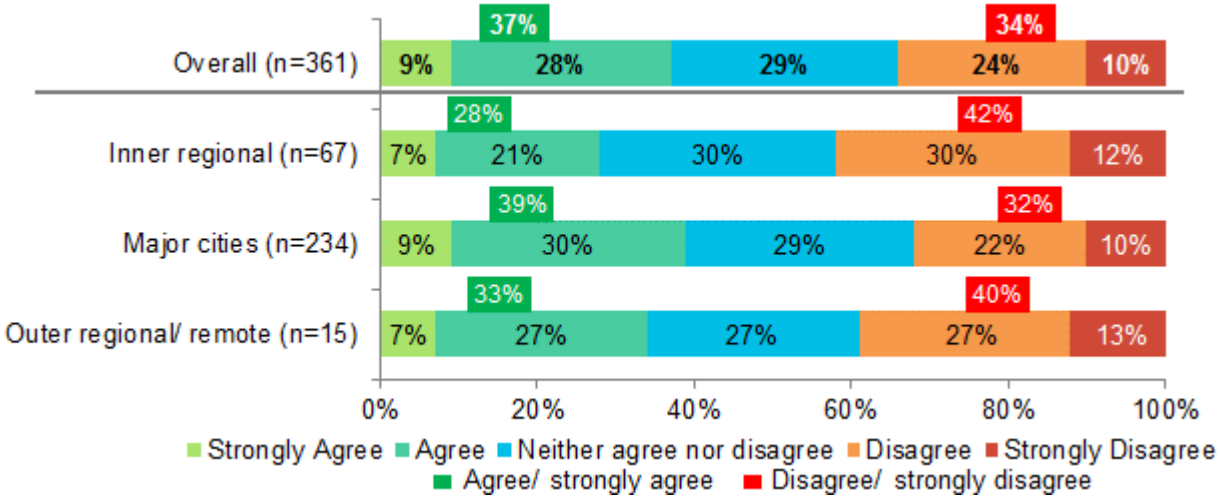



Figure 124: Level of agreement that the Commission has effectively engaged and consulted with *the whole community*, overall and by remoteness category (n=361)



# 8 How the Commission has worked - Principles

Section 11 of the Act set out the principles governing the work of the Commission. This section of the report addresses the feedback obtained from respondents on whether the Commission's work has remained in keeping with its principles.

Agree/ strongly agree proportions varied between 34% and 67% for the principles assessed in submissions.

Respondents were most positive about the Commission having:

- worked to the principles that people with mental illness should have access to the best possible care, are treated with dignity and respect, and are supported to live fully in community life and lead meaningful lives (67%)
- enhanced communication and collaboration with consumers, carers and stakeholders (53%)
- operated from a *whole of government* and *whole of community* perspective (42%).

The lowest proportions of agreement were recorded for enhanced integration and coordination across the sector having existed, including in the areas of health, housing, employment, education and justice (34%), and for clarity of alignment having existed between the work of the Commission and other NSW Government agencies (38%).

As was typical, organisations were significantly more positive than individuals about the Commission having worked to each of its principles.[19]

## 8.1 The best possible care, dignity and respect, and meaningful lives

Three of the Commission's governing principles, under the Act, are that:

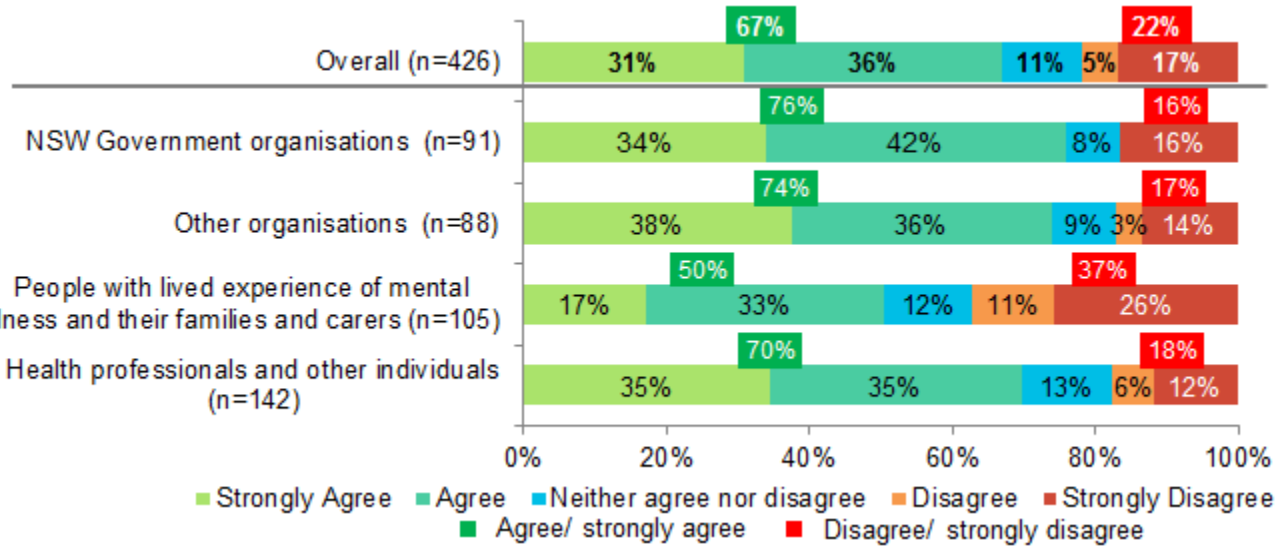
- *people who have a mental illness, wherever they live, should have access to the best possible mental health care and support*
- *people who have a mental illness and their families and carers should be treated with respect and dignity*

[19] Except for the last two, regarding alignment of the Commission's work with other NSW Government agencies and with the broader mental health system, as the online consultation survey did not request feedback from individuals on these two principles.

- *the primary objective of the mental health system should be to support people who have a mental illness to participate fully in community life and lead meaningful lives.*

Two thirds (67%) of submissions agreed/ strongly agreed that the Commission works to the relevant quality of care principles for people with mental illness. Out of the four broad segments, three showed high levels of endorsement (70% or higher). The exception was the segment including people with lived experience of mental illness and their carers (50%).

Figure 125: Level of agreement that the Commission *works to the principles that people with mental illness should have access to the best possible care, are treated with dignity and respect, and are supported to live fully in community life and lead meaningful lives*, overall and by high level organisation and individual groupings (n=426)




Peak bodies were notably positive in this regard (87%); whereas mental health provider organisations were less positive (66%).

Among individuals, carers were significantly less likely to agree/ strongly agree with this statement (50%). Those with lived experience of mental illness were also less likely to agree/ strongly agree (51%), whereas health professionals were more likely (67%); although these differences were not statistically significant.

See Figure 126 to Figure 130 for each segment group's responses to this measure.

Figure 126: Organisations' level of agreement that the Commission *works to the principles that people with mental illness should have access to the best possible care, are treated with dignity and respect, and are supported to live fully in community life and lead meaningful lives*, overall and by organisation type (n=179)

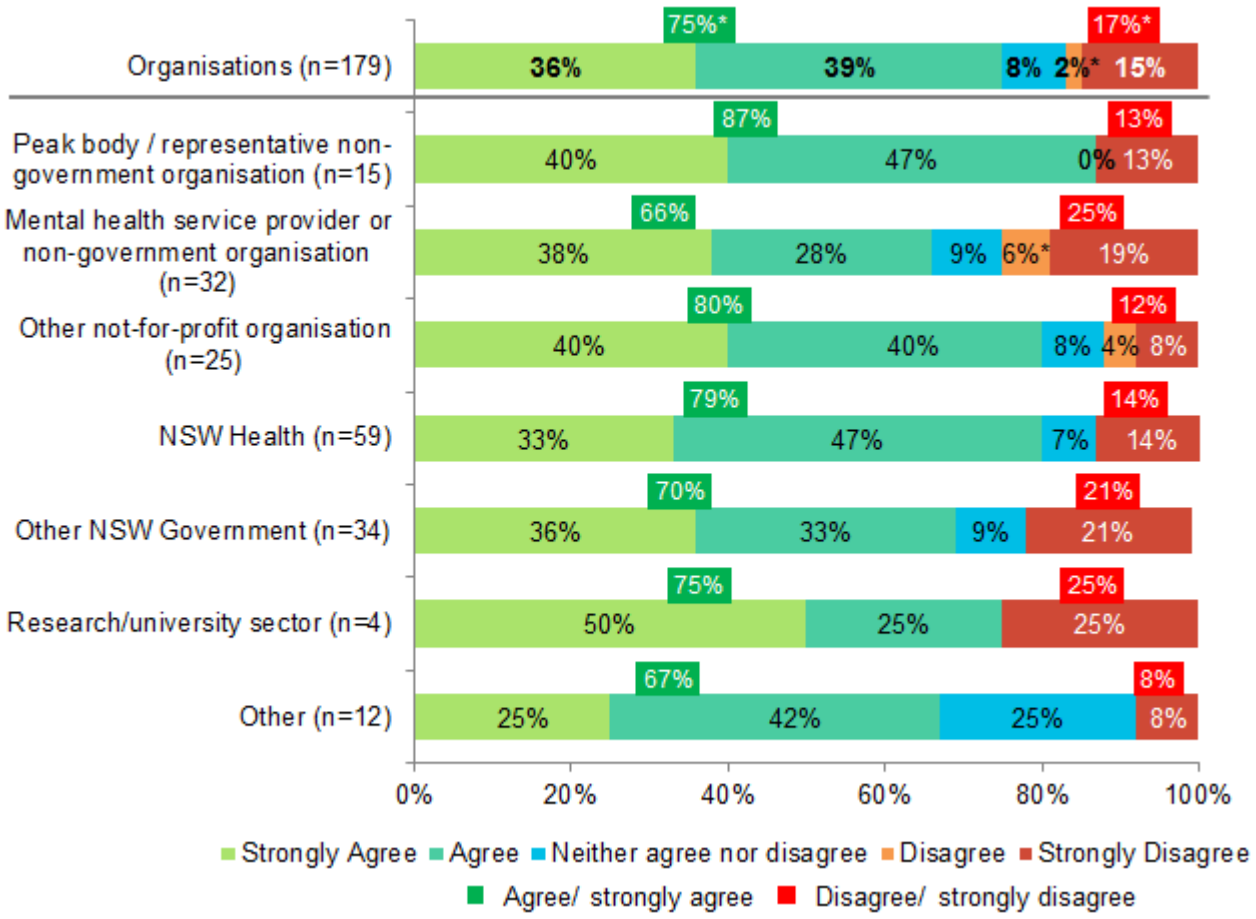


Figure 127: Individuals' level of agreement that the Commission *works to the principles that people with mental illness should have access to the best possible care, are treated with dignity and respect, and are supported to live fully in community life and lead meaningful lives*, overall and by individual background (n=247)

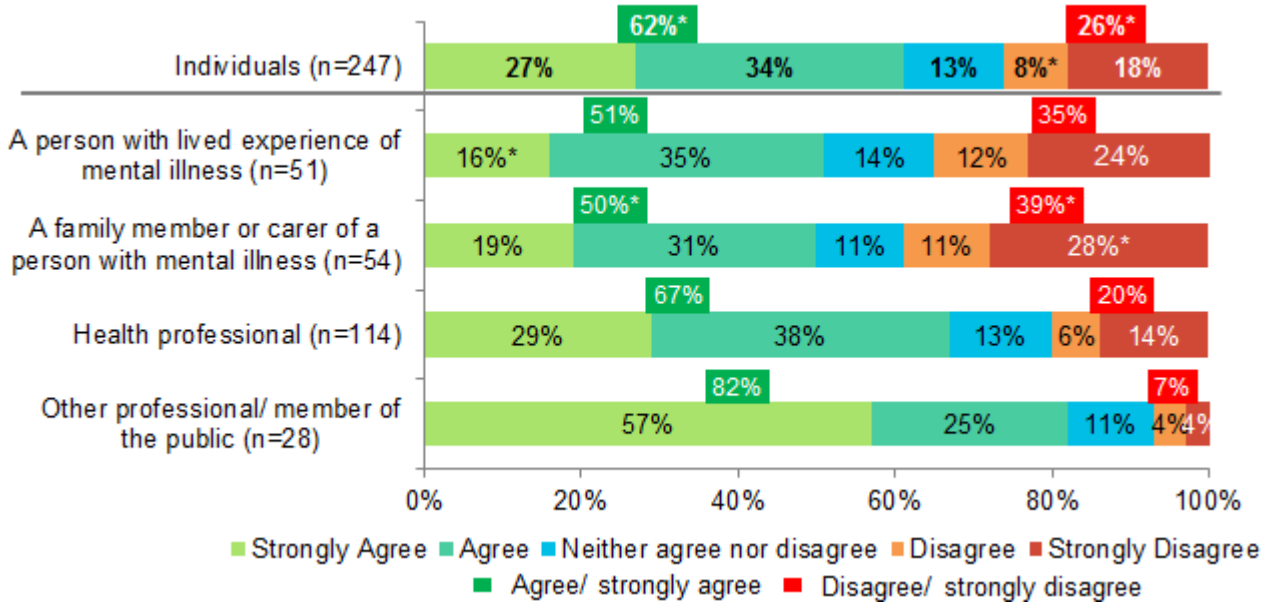



Figure 128: Level of agreement that the Commission *works to the principles that people with mental illness should have access to the best possible care, are treated with dignity and respect, and are supported to live fully in community life and lead meaningful lives*, by Aboriginal and Torres Strait Islander origin (n=243)

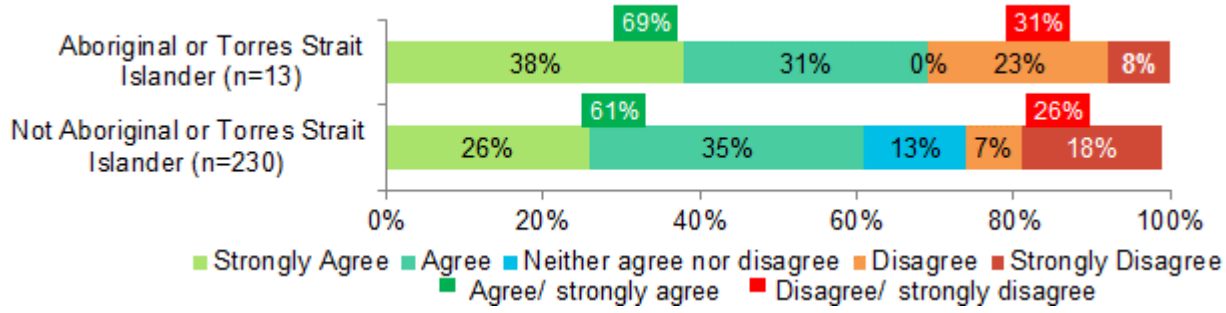


Figure 129: Level of agreement that the Commission *works to the principles that people with mental illness should have access to the best possible care, are treated with dignity and respect, and are supported to live fully in community life and lead meaningful lives*, by culturally and linguistically diverse categories (n=244)

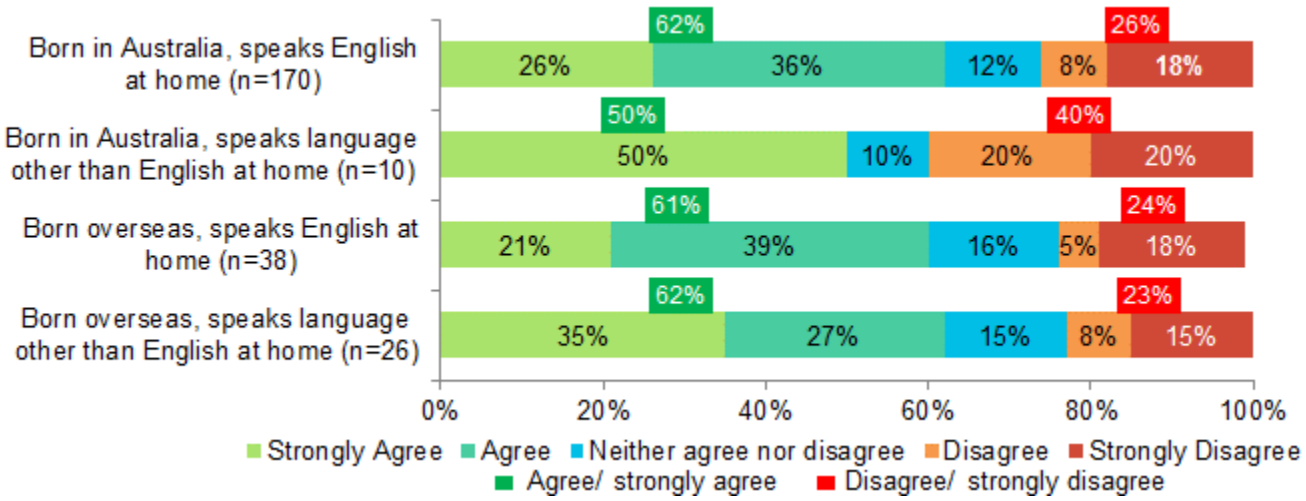
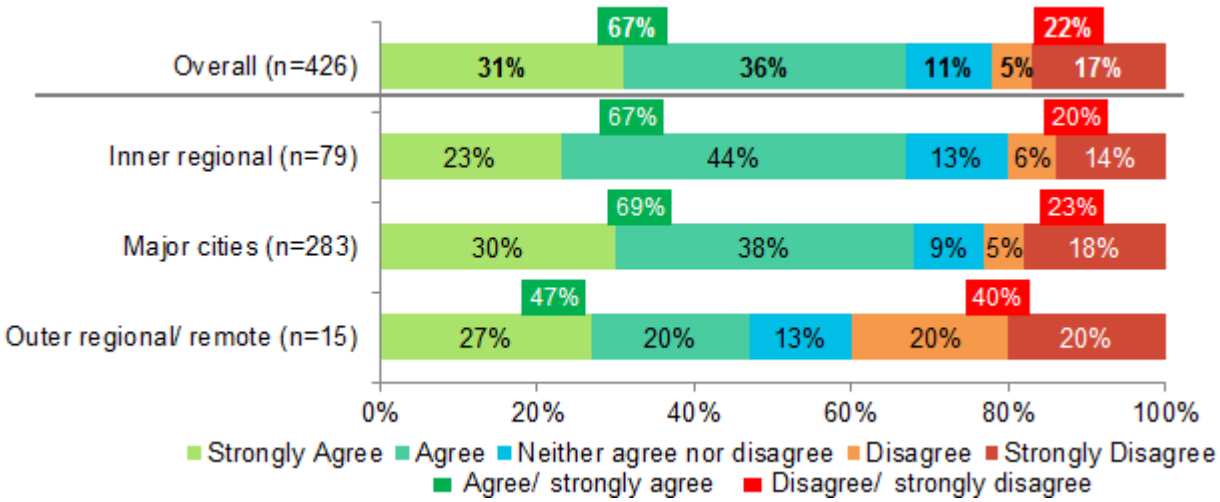



Figure 130: Level of agreement that the Commission *works to the principles that people with mental illness should have access to the best possible care, are treated with dignity and respect, and are supported to live fully in community life and lead meaningful lives*, overall and by remoteness category (n=426)



## 8.2 Collaboration and integration

The final principle outlined under the Act, for the Commission to operate by, is that *an effective mental health system requires:*

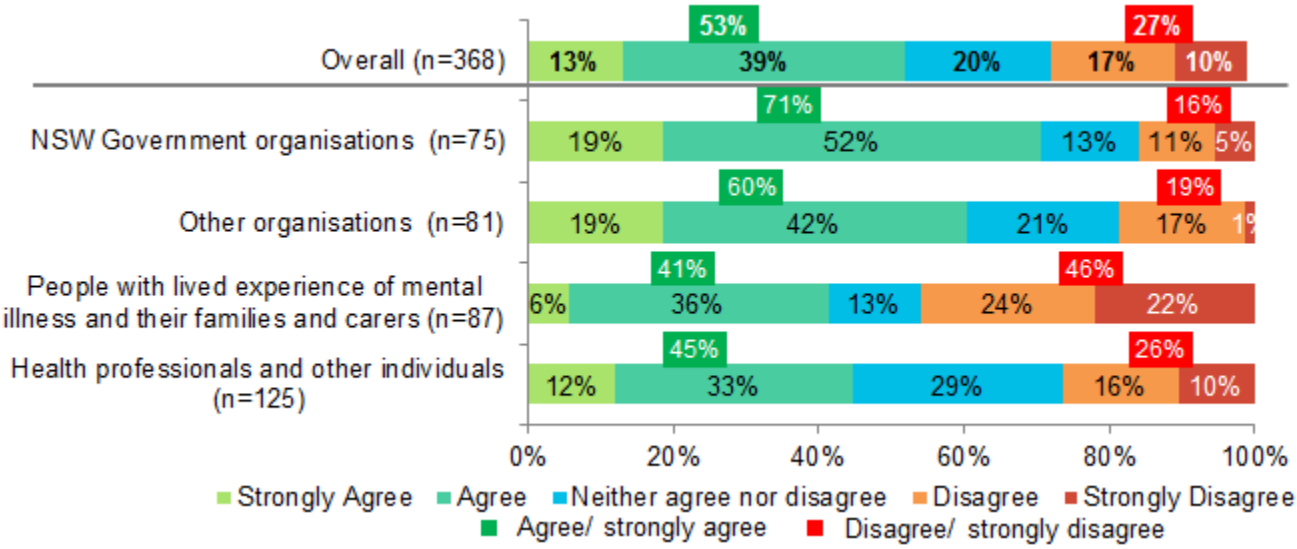
- *communication and collaboration between people who have a mental illness and their families and carers, providers of mental health services and the whole community*
- *a co-ordinated and integrated approach across all levels of government and the non-government sector, including in the areas of health, housing, employment, education and justice.*

## 8.2.1 Consumers, carers and stakeholders

Around one in two (53%) of submissions agreed/strongly agreed with the consultation question relating to whether the Commission has enhanced communication and collaboration with its stakeholders. Just over a quarter (27%) disagreed/ strongly disagreed, and a high proportion (20%) put themselves in the 'neither' category (perhaps indicating that respondents did not have the knowledge or awareness to voice an opinion).

NSW Government and other organisations, the stakeholders the Commission is likely to have most direct contact with, were most positive about the Commission's efforts in this area (71% and 60% agree/ strongly agreed that communication had been enhanced by the Commission). People with lived experienced of mental illness and their families and carers, and health professionals, were less aware of communication having been enhanced (41% and 45% agreed/strongly agreed, respectively).

Figure 131: Level of agreement that the Commission has *enhanced communication and collaboration with consumers, carers and stakeholders*, overall and by high level organisation and individual groupings (n=368)



Organisations were once again more positive than individuals (65% vs 43%).

Levels of agreement were relatively low among peak bodies (57% agreed/ strongly agreed) and not for profit organisations (52%); and relatively high among 'other' NSW government (78%) and the academic sector (75%).

Figure 132: Organisations' level of agreement that the Commission has *enhanced communication and collaboration with consumers, carers and stakeholders*, overall and by organisation type (n=156)

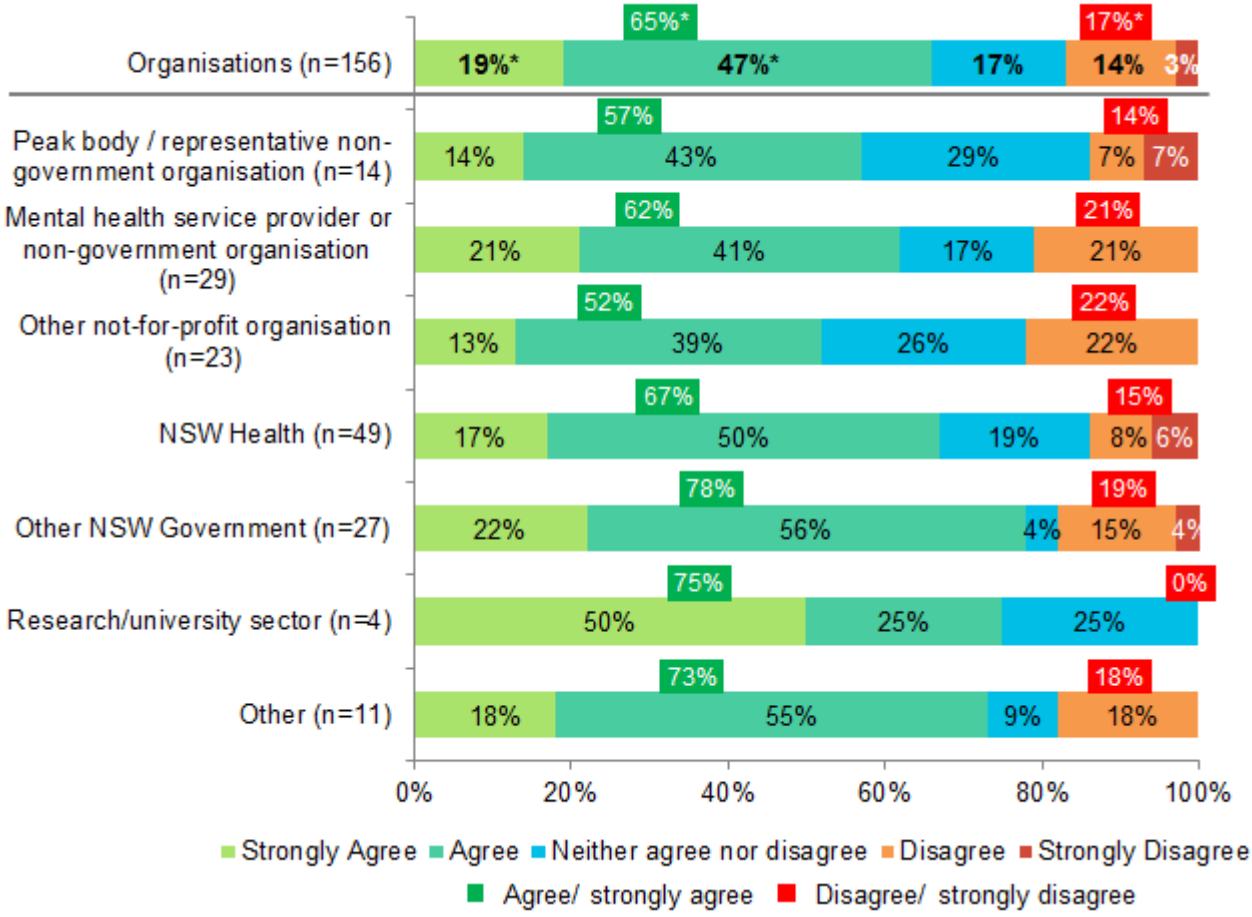
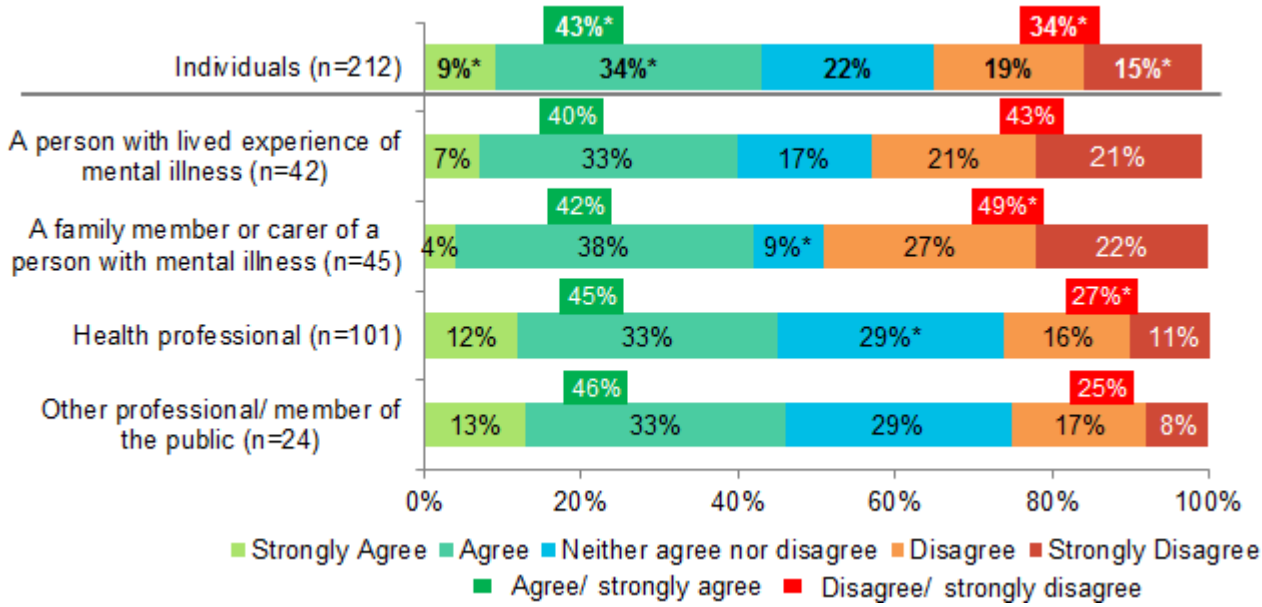


Figure 133: Individuals' level of agreement that the Commission has *enhanced communication and collaboration with consumers, carers and stakeholders*, overall and by individual background (n=212)




Submissions from Aboriginal respondents were notably less positive (27%) than those from the mainstream population (45%). Similarly, submissions from language other than English respondents born overseas were less positive (35%) than all of the other groups.

See Figure 134 and Figure 135.

Figure 134: Level of agreement that the Commission has *enhanced communication and collaboration with consumers, carers and stakeholders*, by Aboriginal and Torres Strait Islander origin (n=208)

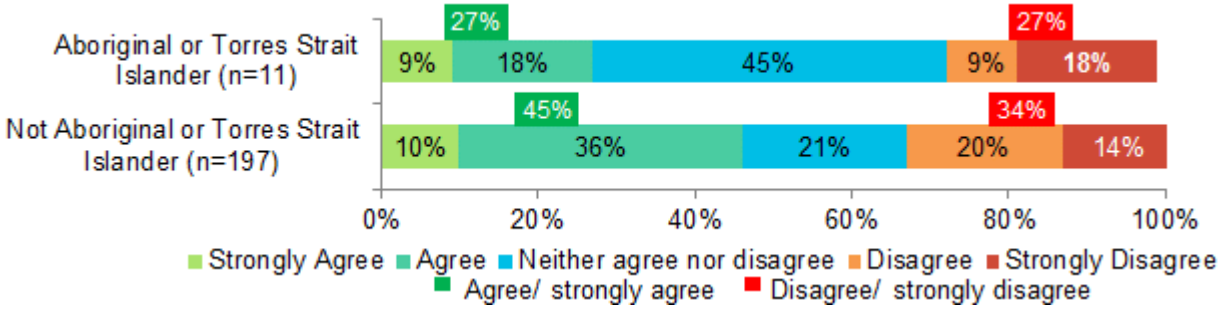
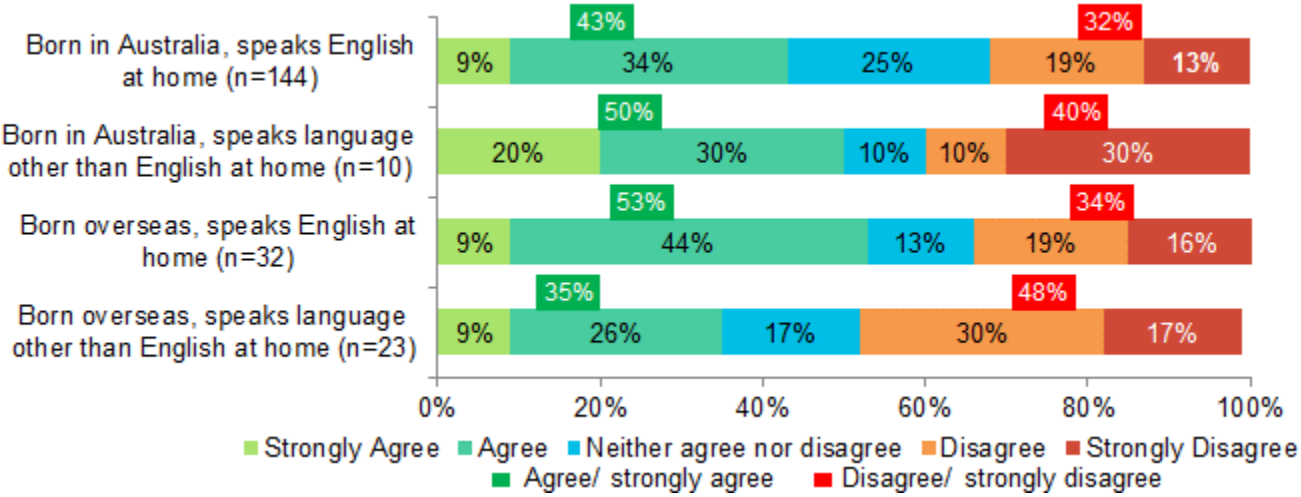
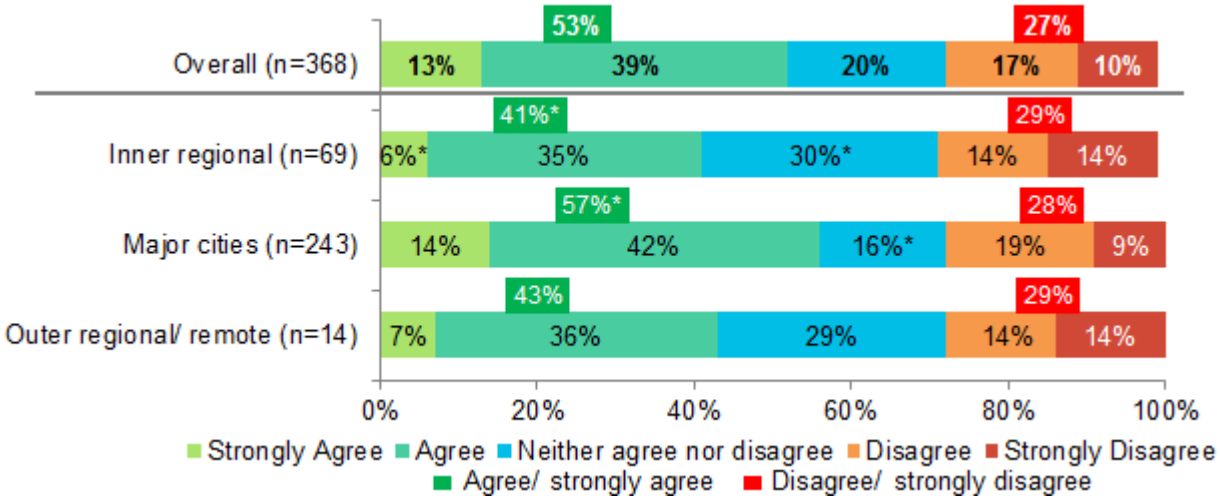


Figure 135: Level of agreement that the Commission has *enhanced communication and collaboration with consumers, carers and stakeholders*, by culturally and linguistically diverse categories (n=209)




Respondents in major cities were significantly more positive than those in inner regional areas (57% and 41% respectively).

Figure 136: Level of agreement that the Commission has *enhanced communication and collaboration with consumers, carers and stakeholders*, overall and by remoteness category (n=368)

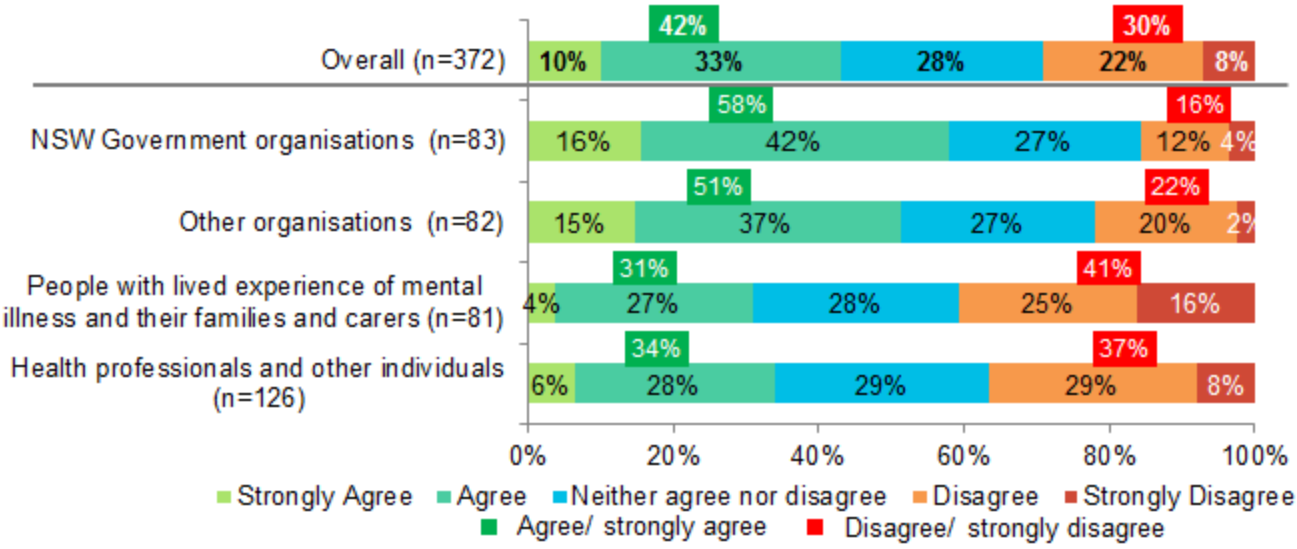


## 8.2.2 Holistic perspective

The consultation asked for views on whether the Commission had acted from a 'whole of government' and 'whole of community' perspective. Nearly three in ten (28%) of submissions indicated that they neither agreed nor disagreed with this statement (perhaps indicating a lack of necessary understanding or awareness to voice an opinion). Two fifths (42%) of submissions agreed/ strongly agrees that the Commission had taken a holistic approach, and three in ten (30%) disagreed/ strongly disagreed.

Levels of agreement ranged from around a third of the individual segments, through to more than a half of NSW Government and other organisations.

Figure 137: Level of agreement that the Commission has *operated from a 'whole of government' and 'whole of community' perspective,* overall and by high level organisation and individual groupings (n=372)




Within organisations, peak bodies and NGOs were the least positive (36%), and those from 'other' NSW government (71%) and the academic sector (75%) were the most. Submissions from individuals with lived experience of mental illness were less positive (23%) than those of carers/family members (39%).

There were also marked differences by ethnicity, with the lowest level of agreement among people from English speaking households who were born overseas (22%) and in Australia (31%). Higher levels of agreement were found among language other than English speaking individuals, both those born in Australia (45%) and born overseas (56%). Similarly, Aboriginal Australians were less positive around the extent to which the Commission operates holistically (9% compared with 35% of non-Aboriginal Australians).

Submissions from those living in cities were more positive (44%) than those living in inner regional (36%) and outer regional/remote locations (23%).

Figure 138 to Figure 142 contain these results.

Figure 138: Organisations' level of agreement that the Commission has *operated from a 'whole of government' and 'whole of community' perspective*, overall and by organisation type (n=165)

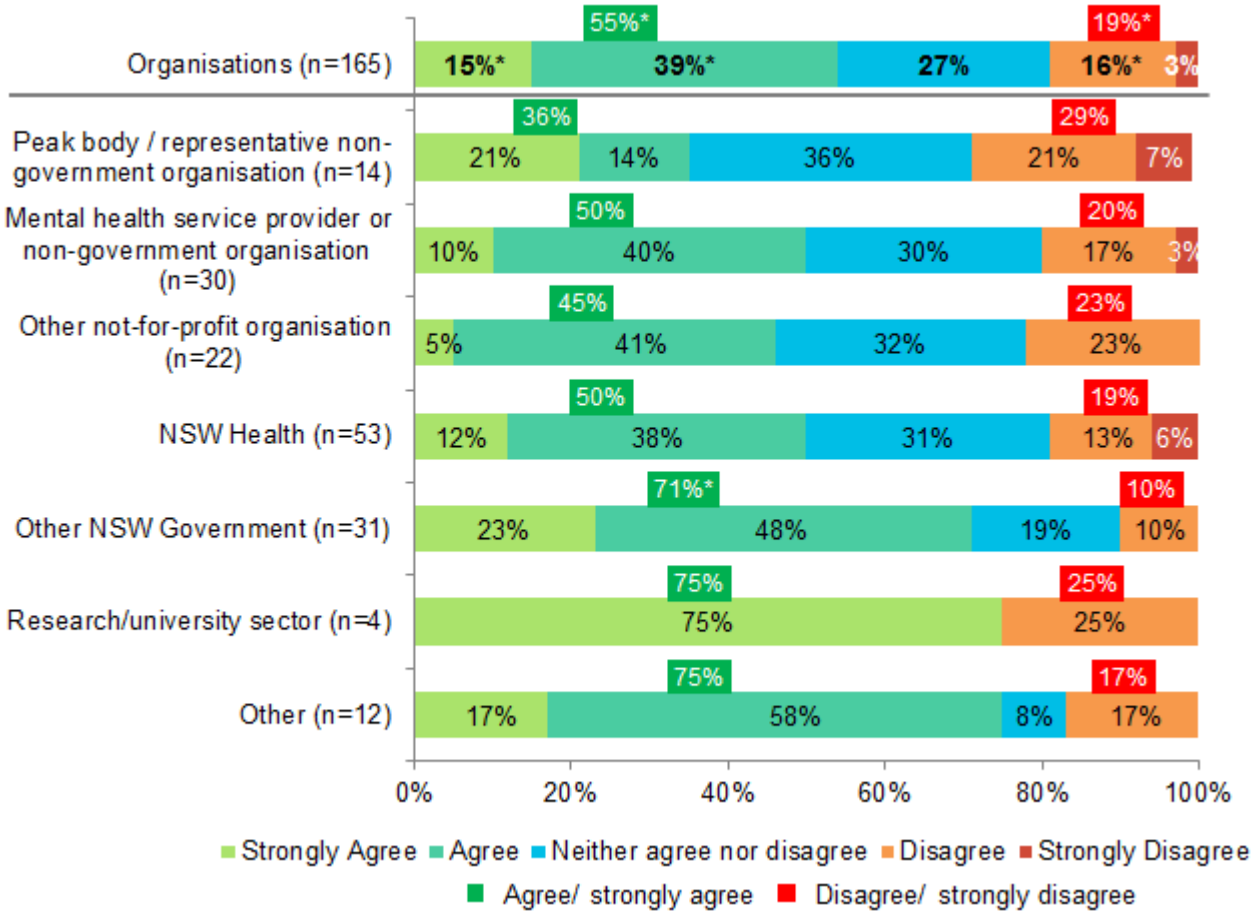


Figure 139: Individuals' level of agreement that the Commission has *operated from a 'whole of government' and 'whole of community' perspective*, overall and by individual background (n=207)

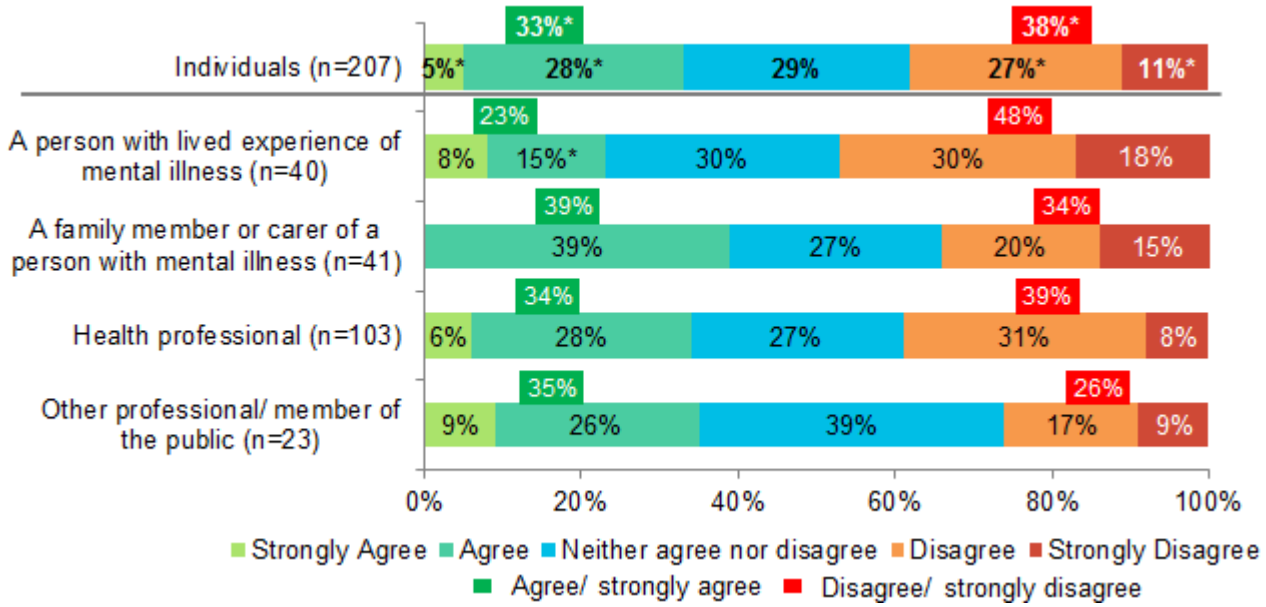



Figure 140: Level of agreement that the Commission has *operated from a 'whole of government' and 'whole of community' perspective*, by Aboriginal and Torres Strait Islander origin (n=204)

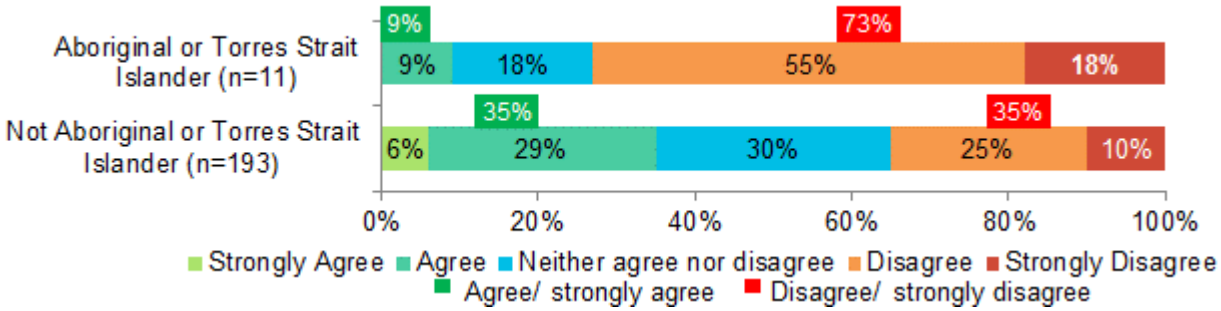


Figure 141: Level of agreement that the Commission has *operated from a 'whole of government' and 'whole of community' perspective*, by culturally and linguistically diverse categories (n=206)

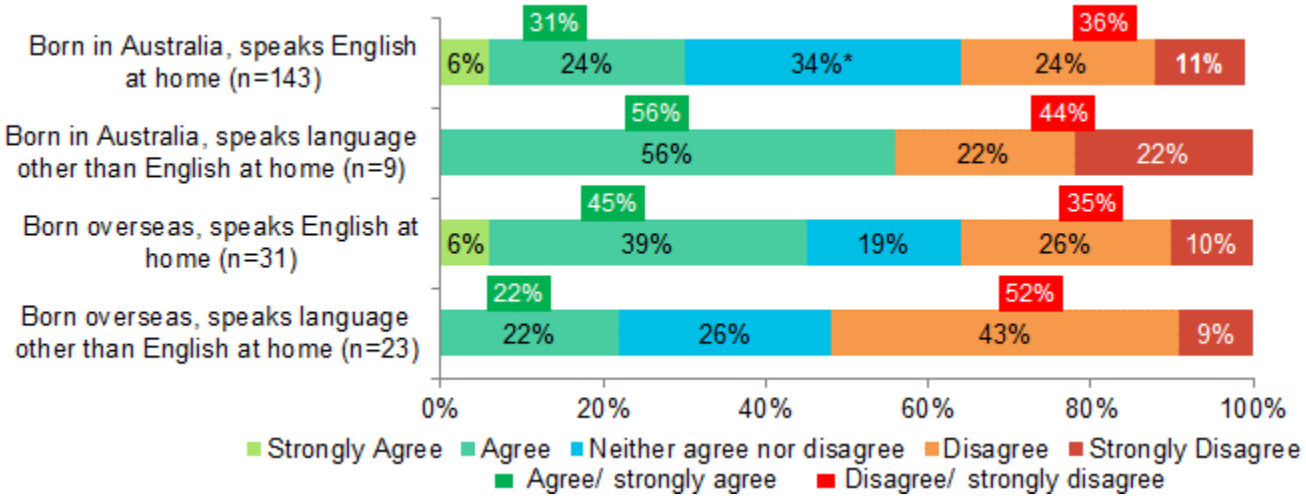
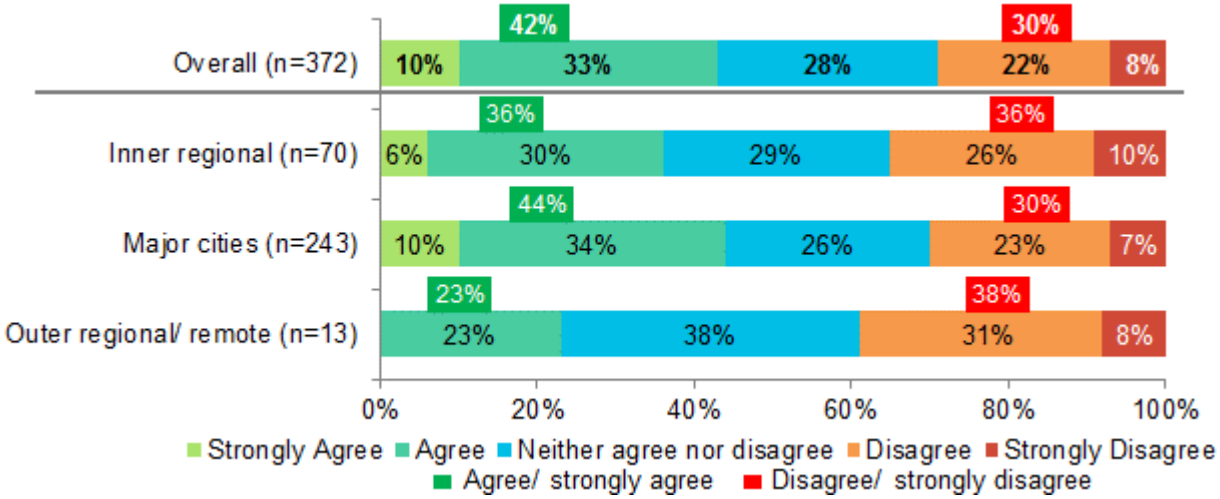


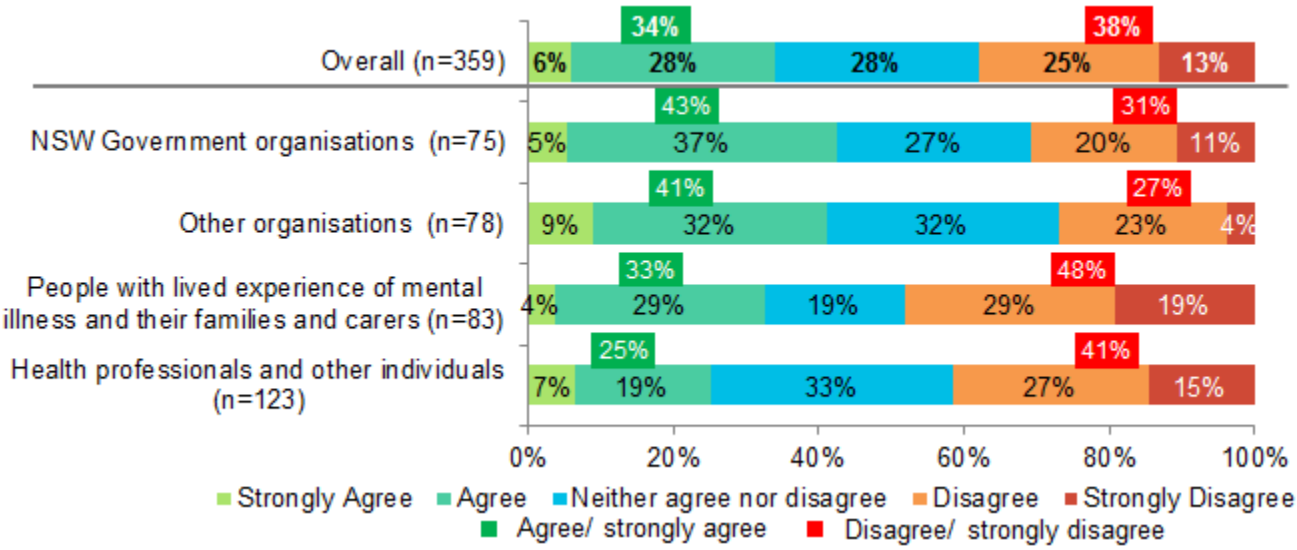

Figure 142: Level of agreement that the Commission has *operated from a 'whole of government' and 'whole of community' perspective*, overall and by remoteness category (n=372)



## 8.2.3 Coordination across the sector

In response to the consultation question regarding whether the Commission has enhanced integration and coordination across the sector, submissions were equally split between broad agreement (34%) and broad disagreement (38%), with more than a quarter (28%) remaining neutral. Submissions from NSW Government were the most positive in response to this statement (43%) while health professionals and other individuals were the least (25%).

Figure 143: Level of agreement that the Commission has *enhanced integration and coordination across the sector, including in the areas of health, housing, employment, education and justice,* overall and by high level organisation and individual groupings (n=359)




The recurring theme of organisations being significantly more positive than individuals was evident (42% and 28% respectively).

Within organisations, too, some of the recurrent patterns emerged, with higher levels of agreement among academics (75%) and 'other' NSW government (56%). In contrast, some of the other public sector agency submissions had relatively low levels of agreement, including peak bodies (31%), 'other' not for profits (32%) and NSW Health (35%).

Only around one fifth (22%) of submissions from health professionals endorsed the Commission's work in this respect; men were more positive than women (31% vs 22%) and submissions from non-Aboriginal Australians showed higher levels of agreement (30%) than those from Aboriginal individuals (9%).

Refer to figures from Figure 144 to Figure 148 for the results for this question.

Figure 144: Organisations' level of agreement that the Commission has *enhanced integration and coordination across the sector, including in the areas of health, housing, employment, education and justice*, overall and by organisation type (n=153)

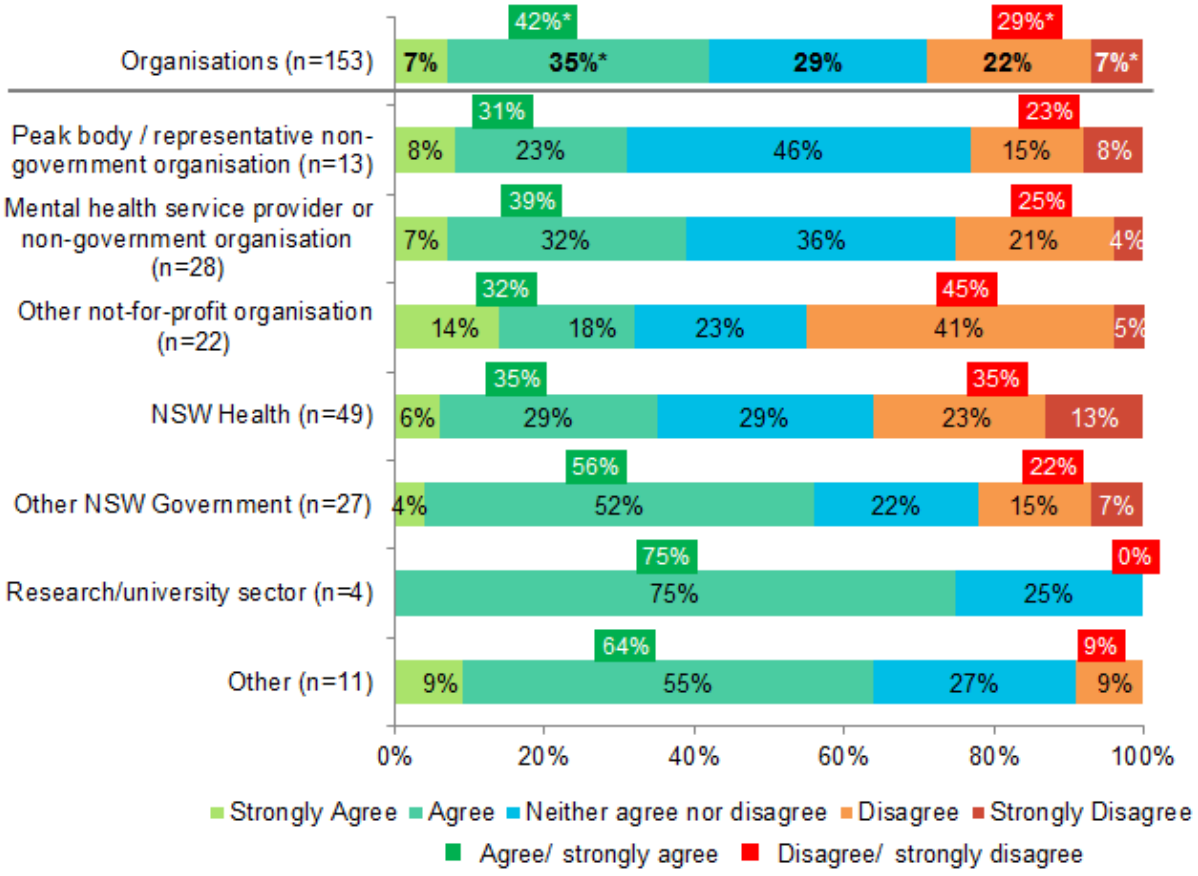


Figure 145: Individuals' level of agreement that the Commission has *enhanced integration and coordination across the sector, including in the areas of health, housing, employment, education and justice*, overall and by individual background (n=206)

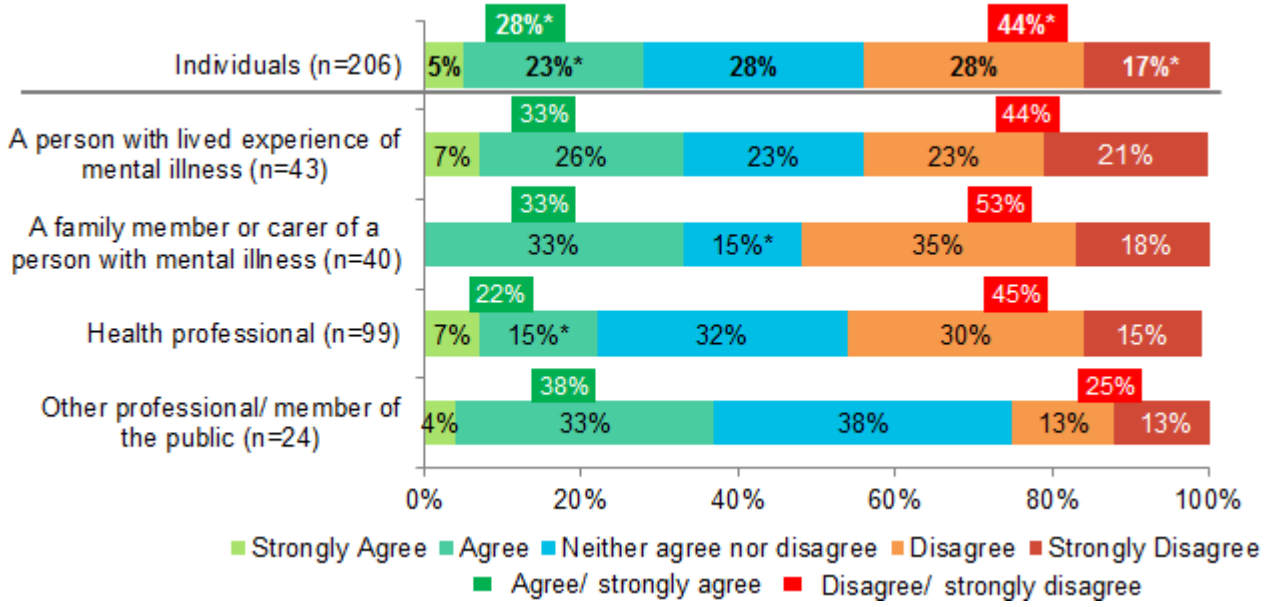



Figure 146: Level of agreement that the Commission has *enhanced integration and coordination across the sector, including in the areas of health, housing, employment, education and justice*, by Aboriginal and Torres Strait Islander origin (n=202)

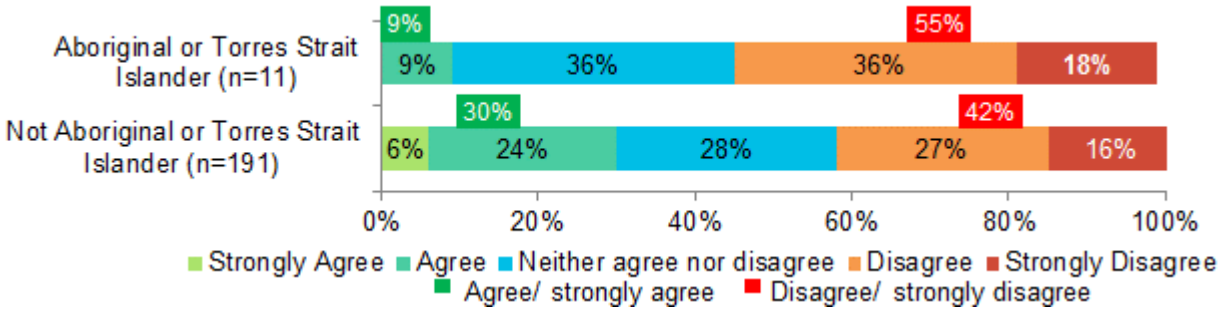


Figure 147: Level of agreement that the Commission has *enhanced integration and coordination across the sector, including in the areas of health, housing, employment, education and justice*, by culturally and linguistically diverse categories (n=203)

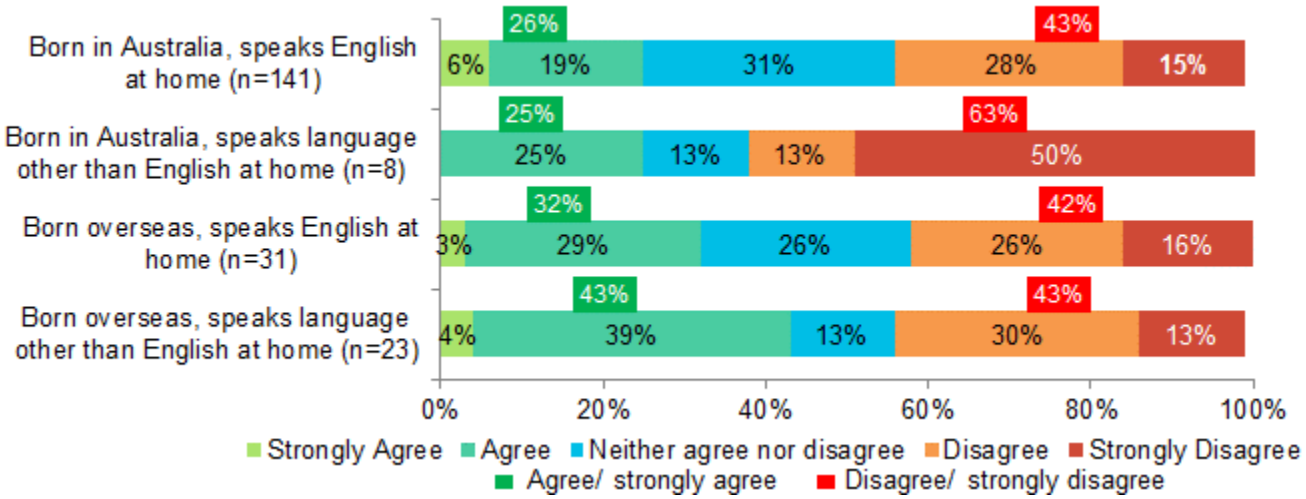
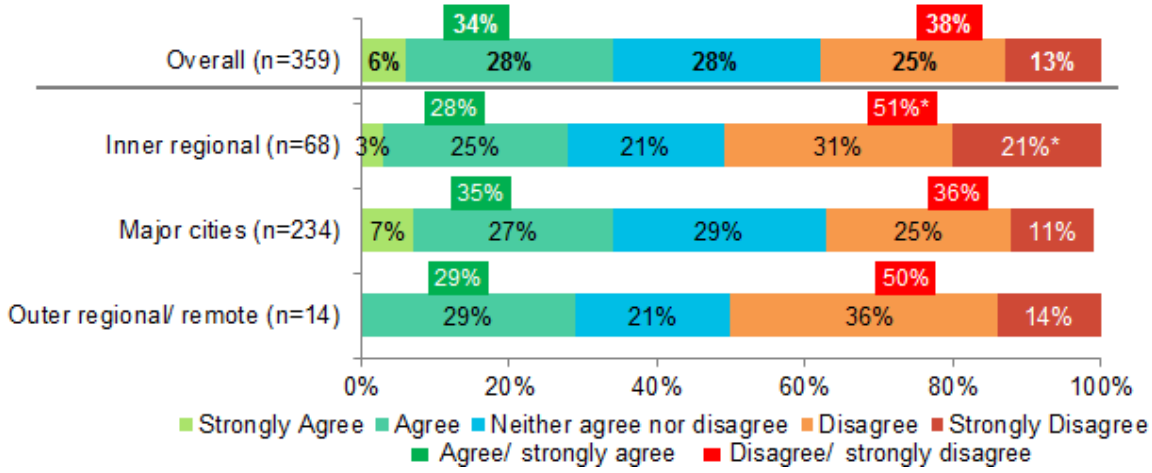



Figure 148: Level of agreement that the Commission has *enhanced integration and coordination across the sector, including in the areas of health, housing, employment, education and justice*, overall and by remoteness category (n=359)



# 8.3 Alignment between the work of the Commission and others

Under the Act, the fourth principle which governs the Commission's work is that *the promotion of good mental health and the effective provision of mental health services are the shared responsibility of the government and non-government sectors*, so the online consultation survey asked respondents from specific organisation types whether they considered the work of the Commission to have been closely aligned with that of other NSW Government agencies, or with the broader mental health system.

## 8.3.1 Alignment with NSW Government agencies

Those who indicated that their submission was from within NSW Health, or other NSW Government agencies, were asked whether they considered the work of the Commission to be aligned with that of other state government agencies. Again, results were polarised, with just over a third both agreeing/ strongly agreeing (38%) and disagreeing/ strongly disagreeing (36%). The remaining quarter (26%) neither agreed nor disagreed. (See Figure 149.)

Interestingly, NSW Health submissions were less likely to agree with this statement (30%, compared with 50% of submissions from other government agencies within NSW), as shown in Figure 150.

Figure 149: Level of agreement that *there is clarity of alignment between the work of the Commission and other NSW Government agencies*, overall and by high level organisation grouping (n=84)

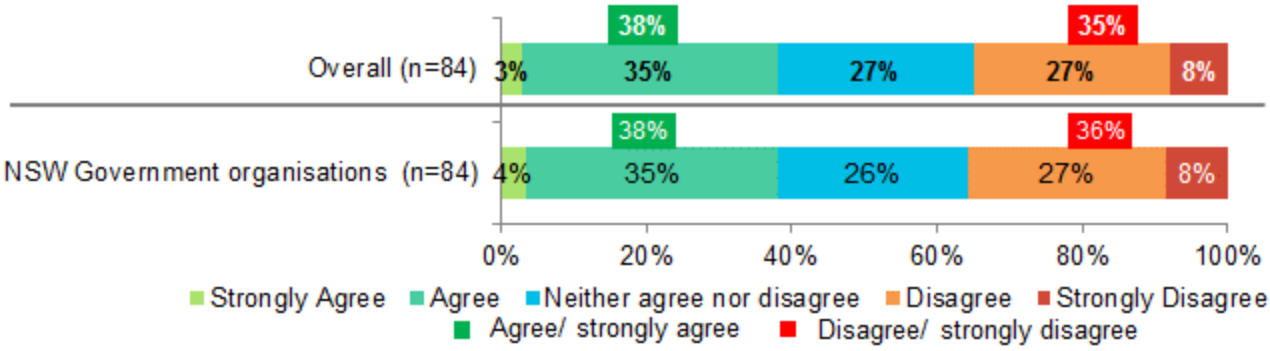


Figure 150: Organisations' level of agreement that *there is clarity of alignment between the work of the Commission and other NSW Government agencies*, overall and by organisation type (n=84)

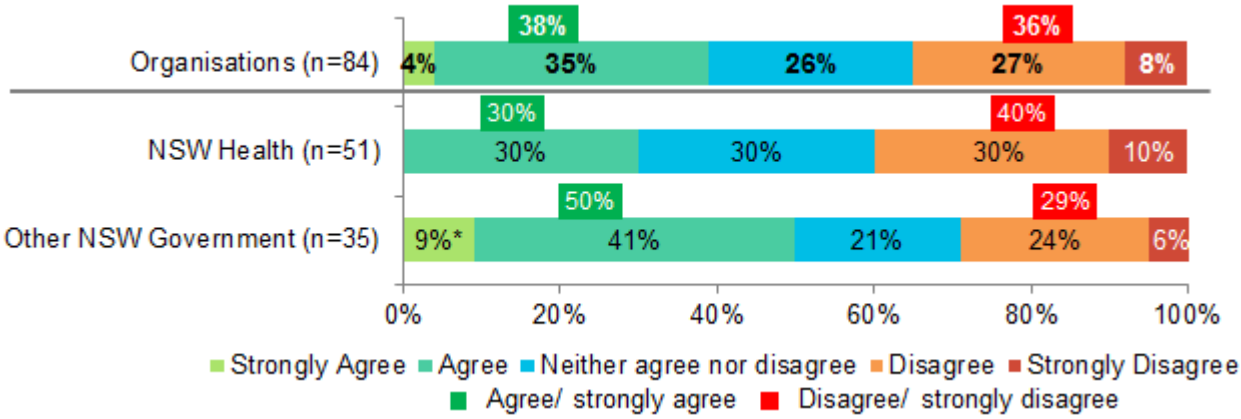
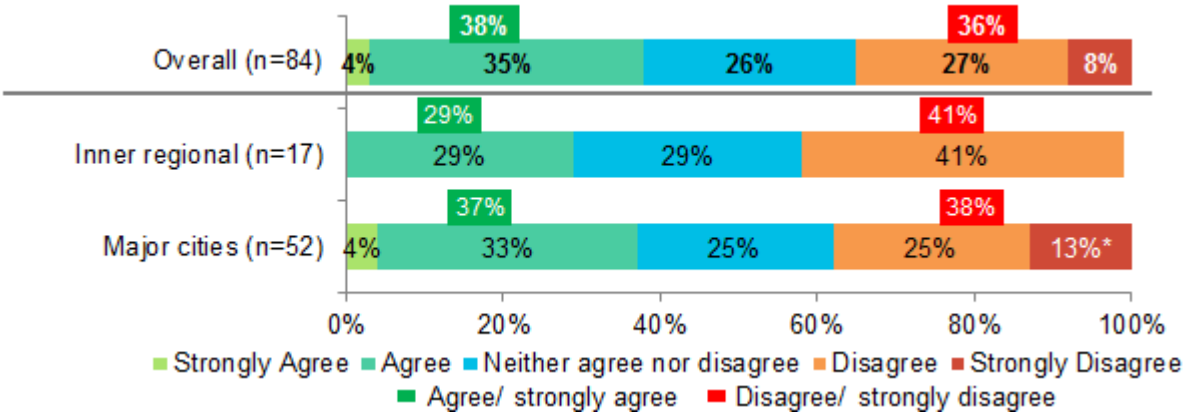



Figure 151: Level of agreement that *there is clarity of alignment between the work of the Commission and other NSW Government agencies*, overall and by remoteness category (n=84)



## 8.3.2 Alignment with the broader mental health system

Non-government organisations were asked to rate their level of agreement with a statement that the work of the broader mental health system and the work of the Commission were clearly aligned.

Submissions were more positive about the Commission's alignment with the broader health system, with two fifths (40%) of responses agreeing/ strongly agreeing and one fifth (21%) disagreeing/ strongly disagreeing. There was a relatively high proportion of neutral responses for this question (39%).

As shown in Figure 153, Peak bodies and other not for profits were relatively unlikely to agree with this statement (19% and 33% respectively) compared with mental health service providers (45%) and the academic sector (75%).

Figure 152: Level of agreement that *the work of the broader mental health system and the work of the Commission are clearly aligned*, overall and by high level organisation grouping (n=80)

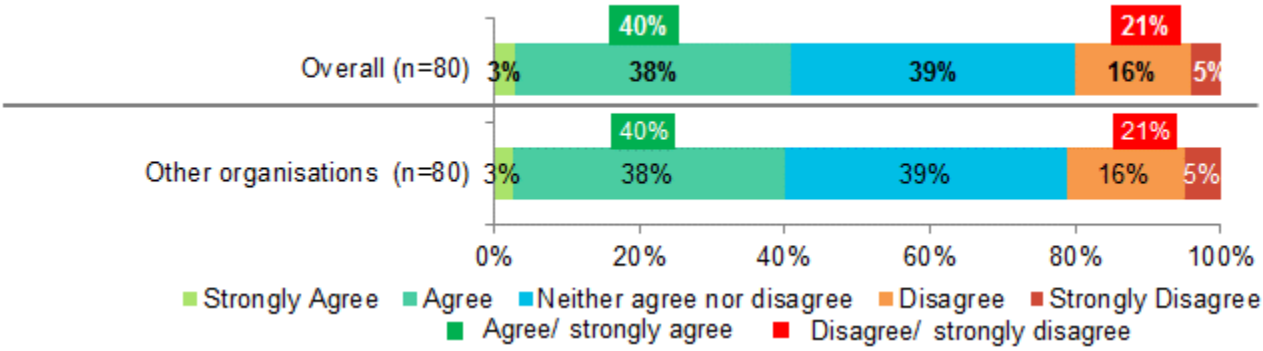


Figure 153: Organisations' level of agreement that *the work of the broader mental health system and the work of the Commission are clearly aligned*, overall and by organisation type (n=80)

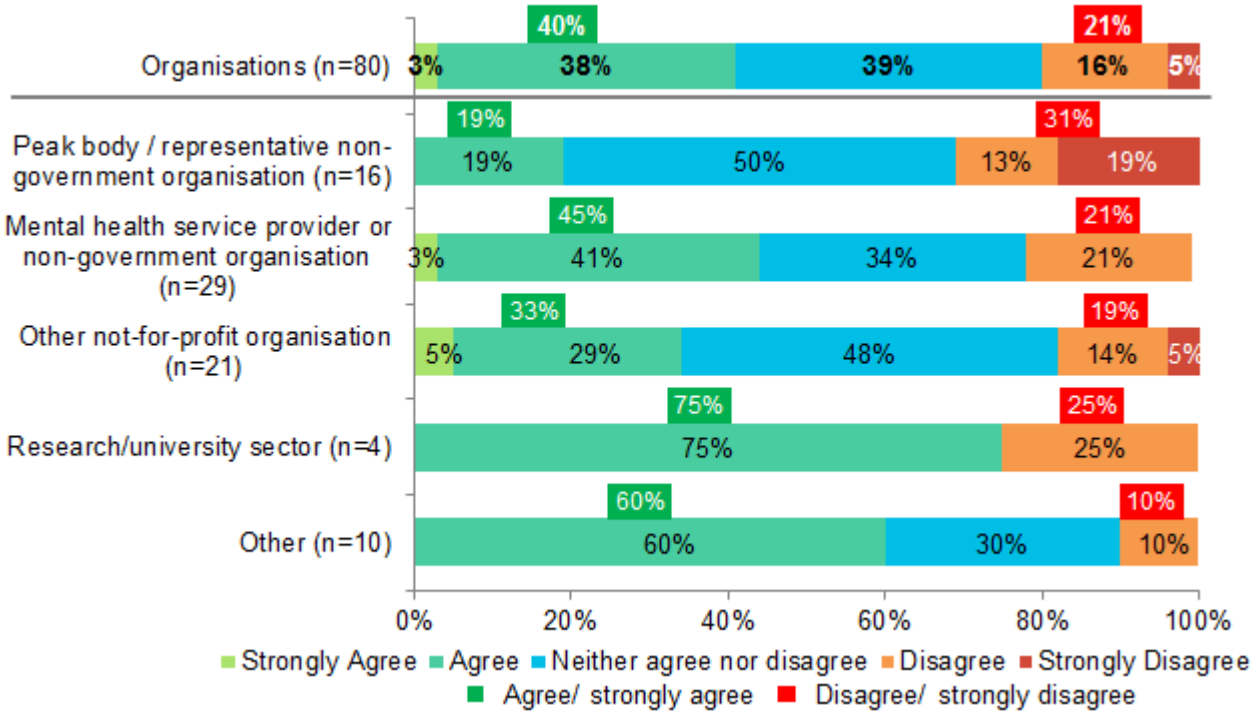
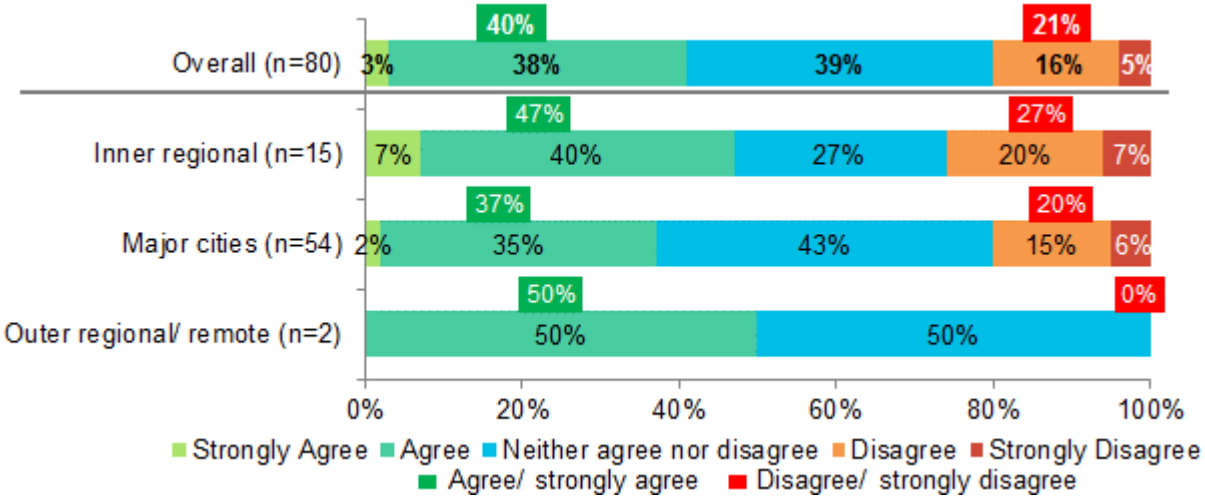



Figure 154: Level of agreement that *the work of the broader mental health system and the work of the Commission are clearly aligned*, overall and by remoteness category (n=80)



## 8.4 Future principles

All respondents were asked whether they thought that the same principles that currently govern the work of the Commission should continue to underpin the Commission's work, or whether they thought any changes should be considered, and, if so, what changes?

Thirty-nine percent of overall submissions indicated that the same principles should continue to apply, without change (39%). This proportion was markedly higher among NSW Government submissions (56%) and other organisations (45%) than among individuals with lived experience and their carers (25%) and other individuals (35%).

When changes to the principles were suggested, it was usually as additions rather than replacements, with 15% of respondents suggesting a greater focus on cross-sector collaborations and integration "between government, its services, and the community." A similar proportion overall (14%) said that the principles were fine, but their application in real life needed improvement.

Just under a quarter (23%) of individuals with lived experience/carers suggested that the principles should focus more on consumers and their rights.

Table 52: Top three comments about future principles, overall and by high level organisation and individual groupings

| Topics | n= | Overall | NSW Government organisations | Other organisations | People with lived experience of mental illness and their families and carers | Health professionals and other individuals |
|---|---|---|---|---|---|---|
| | | 256 | 55 | 55 | 61 | 85 |
| Yes/ no changes needed/ continue as is | | 39% | 56% | 45% | 25% | 35% |
| Enhanced integration/ holistic approach/ coordination with other departments/ services | | 15% | 20% | 16% | 11% | 13% |
| Principles fine, but translate to practice/ delivery more/ more effectively | | 14% | 11% | 5% | 16% | 19% |
| More consumer/ rights engagement/ focus | | 11% | 5% | 4% | 23% | 9% |
| Inequities/ equal access to MH services | | 6% | 4% | 11% | 5% | 6% |

Half of organisations (51%), significantly more than the third of individuals (31%), though that the Commission's operating principles should remain unchanged. All organisation types, apart from peak bodies/ representative non-government organisations, agreed with this stance (38%-80% of other organisation types, 11% of peak bodies/ representative non-government organisations). Peak bodies/ representative non-government organisations and 'other' not-for-profit organisations tended to mention mental health service gaps, and inequalities that they wanted to see addressed, for instance, for rural communities, Aboriginal peoples, or people not eligible for NDIS (22% and 25% respectively).

Table 53: Top three comments about future principles mentioned by organisations, overall and by organisation types

| Topics | n= | Organisations overall 110 | Peak body / representative non-government orgs 9 | Mental health service provider or non-gov org 22 | NSW Health 33 | Other NSW Government 22 | Research/university sector 3 | Other not-for-profit org 16 | Other 5 |
|---|---|---|---|---|---|---|---|---|---|
| Yes/ no changes needed/ continue as is | | 51%* | 11% | 55% | 55% | 59% | 67% | 38% | 80% |
| Enhanced integration/ holistic approach/ coordination with other departments/ services | | 18% | 22% | 14% | 24% | 14% | 33% | 13% | 20% |
| Principles fine, but translate to practice/ delivery more/ more effectively | | 8%* | 11% | 9% | 6% | 18% | - | - | - |
| More consumer/ rights engagement/ focus | | 5%* | - | 5% | 6% | 5% | - | 6% | - |
| Inequities/ equal access to MH services | | 7% | 22% | - | 3% | 5% | - | 25% | - |
| Access to/ focus on education | | 3% | 22% | - | - | 5% | - | - | - |

Some examples of verbatim comments provided by respondents include:

> *"We would agree that these principles should continue to underpin the work of the MHC."* [Other NSW Government]
>
> *"There should be more cross-portfolio action led by MHC NSW."* [Peak body / representative non-government organisation]

*"Yes - but they should actually use them!"* [Mental health service provider or non-government organisation]

*"Yes. Resourcing for rural communities needs to be improved."* [Other not-for-profit organisation]

*"Absolutely … there is still work to be done in educating the community and other parts of government and non-government agencies about such programs as 'Recovery' principals."* [Other NSW Government]

While a third of individuals wanted no changes made to the Commission's principles (31%), 18% (significantly more than overall) wanted to see those principles more effectively applied in practice. A significantly high 32% of respondents with a lived experience of mental illness wanted even more consumer and carer engagement and a person-centred approach to be core. (See table Table 54.)

Table 54: Top three comments about future principles mentioned by individuals, overall and by individual background

| Topics | n= | Individuals overall 146 | A person with lived experience of mental illness 31 | A family member or carer of a person with mental illness 30 | Health professional 67 | Other professional/ member of the public 18 |
|---|---|---|---|---|---|---|
| Yes/ no changes needed/ continue as is | | 31%* | 23% | 27% | 30% | 56% |
| Principles fine, but translate to practice/ delivery more/ more effectively | | 18%* | 16% | 17% | 22% | 6% |
| More consumer/ rights engagement/ focus | | 15%* | 32%* | 13% | 9% | 11% |
| Enhanced integration/ holistic approach/ coordination with other departments/ services | | 12% | 13% | 10% | 13% | 11% |
| Enhanced collaboration with carers | | 3% | - | 13% | - | - |

Some examples of verbatim comments provided by respondents include:

*"Those principles should continue."* [Health professional]

*"No changes are necessary, apart from acting with more impact."* [A family member or carer of a person with mental illness]

*"Equally value the lived experience and see us as the experts."* [A person with lived experience of mental illness]

*"Greater input from relevant education sectors, organisations and MH support services focusing on the current and future needs of the Education/schooling community."* [Health professional]

*"The Mental Health Commission are useless. Who are they? Carers need to have a direct say in the mental health system. We are the ones caring and nobody is asking us for anything. We just have to go with this useless system. I am very angry; it has been such a nightmare for so many years. We get no help whatsoever. It is so bad; the system is bad and the government does not care."* [A family member or carer of a person with mental illness]

Two of the five Aboriginal respondents indicated that they thought that the current principles should remain unchanged.

Table 55: Top three comments about future principles, by Aboriginal and Torres Strait Islander origin

| Topics n= | Aboriginal 5 | Not Aboriginal 139 |
|---|---|---|
| Principles fine, but translate to practice/ delivery more/ more effectively | 20% | 18% |
| Yes/ no changes needed/ continue as is | 40% | 31% |
| More consumer/ rights engagement/ focus | - | 16% |
| Enhanced integration/ holistic approach/ coordination with other departments/ services | 40% | 12% |
| Funding | 20% | 4% |

Some examples of verbatim comments provided by respondents include:

ABORIGINAL AND TORRES STRAIT ISLANDERS:

*"I definitely feel that these principles should continue to underpin the work [of the MHC]."* [A family member or carer of a person with mental illness]

*"I am an Aboriginal Mental Health Worker and in the area I live, there is a lack of services, transport, housing, etc. I feel funding is a huge issue. These issues are ongoing."* [A family member or carer of a person with mental illness]

Respondents born overseas tended to say that the principles should stay as they are slightly less often that those born in Australia (13% of those who spoke a language other than English at home, 25% of those who spoke English at home, compared with 33%-35% of those born in Australia), but more often expressed a wish for greater integration across services and government departments (20% of those who spoke a language other than English at home, 14% of those who spoke English at home, compared with 0%-11% of those born in Australia).

Table 56: Top three comments about future principles, by culturally and linguistically diverse categories

| Topics | n= | Born in Australia, speaks English at home | Born in Australia, speaks language other than English at home | Born overseas, speaks English at home | Born overseas, speaks language other than English at home |
|---|---|---|---|---|---|
| | | 97 | 6 | 28 | 15 |
| Yes/ no changes needed/ continue as is | | 35% | 33% | 25% | 13% |
| Principles fine, but translate to practice/ delivery more/ more effectively | | 22% | 17% | 14% | - |
| More consumer/ rights engagement/ focus | | 13% | 33% | 11% | 27% |
| Enhanced integration/ holistic approach/ coordination with other departments/ services | | 11% | - | 14% | 20% |
| Inequities/ equal access to MH services | | 5% | 17% | 4% | 7% |
| Enhanced collaboration with carers | | 1% | - | 4% | 13% |
| Funding | | 4% | - | - | 13% |

Some examples of verbatim comments provided by respondents include:

BORN IN AUSTRALIA, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

*"Need to be kept."* [A family member or carer of a person with mental illness]

*"I think that the last two questions are very important aspects of the Mental Health Commission's work. However, I am becoming increasingly concerned about the power imbalance that exists between professionals and individuals which can affect the individual's ability to ensure that they are receiving the most appropriate and best possible care."* [A person with lived experience of mental illness]

*"The principles are fine; evidencing the Commission has impacted across a PHN/public/NGO sector mix is hard."* [Health professional]

*"Focus on all communities, not just rural [areas]. Focus on city communities."* [A person with lived experience of mental illness]

BORN OVERSEAS, SPEAKS ENGLISH AT HOME:

*"Agree."* [Other professional]

"*I believe they should underpin the Commission's work. I'm just not sure they have to this point."* [Health professional]

*"Yes. More attention needs to be given to the integration of mental health and addiction services."* [Health professional]

BORN OVERSEAS, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

*"Focus on the principle of engaging consumers, to reach the people that need it the most, who are not working well with services. Focus on the principle of sustainable skill building as part of service delivery to stop people being in services for so long and being dependent on workers and consequently disabled."* [A person with lived experience of mental illness]

*"Still much to be done to ensure all stakeholders participate widely; constantly building trust and rapport along the engagement process."* [Other professional]

*"There has to be more integration and communication across all systems supporting people with mental illness. More funding to make access to treating professionals an affordable reality."* [Health professional]

*"Yes, I do agree. However, carers have been left out of NDIS and there is no clear provision for them. Also, every questionnaire assumes you are a carer OR a consumer, almost always, we are both. That must be changed. Allow me to tick both boxes. I've been a carer all my life and a consumer for more than a decade of that*

*time. Even Centrelink does not accept this as a reality."* [A family member or carer of a person with mental illness]

The proportion agreeing that the same principles should apply decreased slightly in areas away from major cities, down to 22% in outer regional/ remote regions. In outer regional/ remote regions, a third of respondents said that the principles were "fine", but their "translation into lived experience is not so fine" (33%), and this sentiment was echoed in 14% of submissions overall.

Table 57: Top three comments about future principles, overall and by remoteness category

| Topics | n= | Overall 256 | Major cities 175 | Inner regional 45 | Outer regional / remote 9 |
|---|---|---|---|---|---|
| Yes/ no changes needed/ continue as is | | 39% | 42% | 31% | 22% |
| Enhanced integration/ holistic approach/ coordination with other departments/ services | | 15% | 15% | 20% | - |
| Principles fine, but translate to practice/ delivery more/ more effectively | | 14% | 12% | 18% | 33% |
| Inequities/ equal access to MH services | | 6% | 6% | 2% | 22% |

Some examples of verbatim comments provided by respondents include:

MAJOR CITIES:

*"Yes - no changes required to the principles."* [A family member or carer of a person with mental illness]

*"They should continue."* [Health professional]

*"Integration definitely should be included and ramped up."* [Other professional]

*"These principles are good, but the issue our family has faced is about the lack of personal and individual care for the mentally unwell."* [A family member or carer of a person with mental illness]

INNER REGIONAL:

*"Absolutely agree they should underpin the MHC's work. However, the messages are not reaching the work force on the ground, who are, at times, very resistant to*

*change or truly believe they are doing this work, when they are not."* [Health professional]

*"Yes, I think they should."* [Other not-for-profit organisation]

*"A holistic and integrated approach is essential and mental health concerns and programs must include that wide-ranging co-ordination."* [A family member or carer of a person with mental illness]

*"These principles should continue, but there needs to be more work to allow the MHC to work harder to really make a difference to people's lives."* [NSW Health]

OUTER REGIONAL/REMOTE:

*"The principles are fine; the translation into lived experience is not so fine."* [Health professional]

*"Yes, these should continue, but we also need strong advocacy from the Commission back to Government, to continue reforms to the Mental Health Act … in particular, the recognition of psychological harm."* [A family member or carer of a person with mental illness]

*"HELP regional NSW!"* [A person with lived experience of mental illness]

## 8.5 Suggestions for being more strategically focused

All respondents were also asked how they thought the work of the Commission might be more strategically focused, in the context of the broader Government and mental health system.

A third of respondents suggested that the Commission become more strategically focused by working more closely with all stakeholders, from consumers, carers and communities, to health care professionals and service providers (33%).

Continued and increased engagement with people with lived experience of mental illness, with a focus on the ways they are supported and treated, was also important to respondents (27%); as was a 'whole of Government' approach (14%).

Engagement with consumers was particularly important to individuals with lived experience and their carers (50%); while a whole of Government approach was cited most by submissions from NSW Government organisations.

Table 58: Top three suggestions for being more strategically focused, overall and by high level organisation and individual groupings

| Topics | n= | Overall 227 | NSW Government organisations 46 | Other organisations 41 | People with lived experience of mental illness and their families and carers 62 | Health professionals and other individuals 78 |
|---|---|---|---|---|---|---|
| More collaboration/ engagement with stakeholders | | 33% | 39% | 37% | 18% | 40% |
| Engage with actual consumers/ lived experience/ treatment focussed | | 27% | 13% | 17% | 50% | 22% |
| Whole of government approach | | 14% | 26% | 15% | 13% | 6% |
| Increased authority/ power/ scope | | 11% | 2% | 10% | 11% | 15% |

Thirty-eight percent of organisations also thought more collaboration and engagement with all stakeholders was the best approach for the Commission (38%), but significantly more organisations than individuals recommended additional cross-government initiatives and "greater alignment with service provision from other government agencies" (21%). Besides one of the three research/ university sector respondents (33%), NSW Government respondents themselves, both Health and 'other', were the greatest proponents of this (23% of NSW Health, 31% of 'other' NSW Government respondents).

Three of the nine peak bodies/ representative non-government organisations wanted the Commission's authority and scope to be broadened so that it had the "legislative teeth" to "insist on the changes and make sure the laws and regulations are applied vigorously" (33%). (See Table 59.)

Table 59: Top three suggestions for being more strategically focused mentioned by organisations, overall and by organisation types

| Topics | n= | Organisations overall 87 | Peak body / representative non-government orgs 9 | Mental health service provider or non-gov org 16 | NSW Health 30 | Other NSW Government 16 | Research/university sector 3 | Other not-for-profit org 8 | Other 5 |
|---|---|---|---|---|---|---|---|---|---|
| More collaboration/ engagement with stakeholders | | 38% | 67% | 25% | 37% | 44% | 33% | 38% | 20% |
| Whole of government approach | | 21%* | - | 19% | 23% | 31% | 33% | 13% | 20% |
| Engage with actual consumers/ lived experience/ treatment focussed | | 15%* | 22% | 19% | 17% | 6% | - | 25% | - |
| Increased authority/ power/ scope | | 6% | 33% | 6% | 3% | - | - | - | - |
| Work from the ground up | | 7% | - | 19% | - | 13% | - | - | 20% |
| Allocate funding more broadly/ equitably | | 7% | 11% | - | 10% | - | - | 25% | - |
| Standardised objectives & outcome frameworks/ accountability | | 10% | 22% | - | 10% | 13% | 33% | - | 20% |
| Improved access to services/ service delivery | | 8% | 11% | 13% | 7% | 6% | - | - | 20% |

Some examples of verbatim comments provided by respondents include:

> *"This is not a question for the Commission, rather for the other stakeholders. The real question is where is the misalignment?"* [Mental health service provider or non-government organisation]
>
> *"Opportunities need to be identified to take the work to a whole of government approach."* [NSW Health]
>
> *"Working more with stakeholders, carers and people with mental illness and advocating more around the challenges of the NDIS for clients."* [Other not-for-profit organisation]
>
> "*Listening to carers /consumers and doctors. Communicating on a regular basis with the government via our MPs, peak bodies, committees and forums. Insist on the changes and make sure the laws and regulations are applied vigorously."* Peak body / representative non-government organisation]
>
> *"Put resources at the coal face please, not at the top."* [Other NSW Government]
>
> *"Greater reporting responsibility by government … they need to show how each department is addressing the issue of mental health and wellbeing in their organisation."* [Other]

Individuals typically suggested that more engagement with people with lived experience of mental illness was key (34%), with respondents with this lived experience themselves being most likely to (55%), and health professionals being significantly least likely to (19%). Individual health professionals, like organisations, tended to suggest more collaboration and consultation with all stakeholders (42%). (Refer to Table 60.)

Table 60: Top three suggestions for being more strategically focused mentioned by individuals, overall and by individual background

| Topics | n= | Individuals overall | A person with lived experience of mental illness | A family member or carer of a person with mental illness | Health professional | Other professional/ member of the public |
|---|---|---|---|---|---|---|
| | | 140 | 29 | 33 | 67 | 11 |

| Topics n= | Individuals overall 140 | A person with lived experience of mental illness 29 | A family member or carer of a person with mental illness 33 | Health professional 67 | Other professional/ member of the public 11 |
|---|---|---|---|---|---|
| Engage with actual consumers/ lived experience/ treatment focussed | 34%* | 55% | 45% | 19%* | 36% |
| More collaboration/ engagement with stakeholders | 30% | 17% | 18% | 42%* | 27% |
| Increased authority/ power/ scope | 14% | 10% | 12% | 13% | 27% |
| Whole of government approach | 9%* | 14% | 12% | 6% | 9% |
| Standardised objectives & outcome frameworks/ accountability | 6% | 10% | 12% | 3% | - |

Some examples of verbatim comments provided by respondents include:

> *"Support consumer movement preferences regarding legislation for mental health crisis."* [A person with lived experience of mental illness]
>
> *"Enhance its community engagement strategies, so it can reach the grassroots or hard to reach consumers, communities and groups."* [Other professional]
>
> *"Work with the lowest rank mental health staff, then work upwards to senior management."* [Health professional]
>
> *"The Commission should be given powers to investigate all individual cases of abuse and neglect. This would enable them to compile evidence for systemic change … and fill the gap where we disappear when the HCCC, Minister, Ombudsman and community let us down. Some states have active commissions. Why don't we?"* [A person with lived experience of mental illness]
>
> *"Mental health should really be put into the primary health care setting in the future, rather than be fragmented and siloed from the rest of the health service system."* [Health professional]

There were only minor variations in the responses from Aboriginal and non-Aboriginal respondents, as shown in Table 61.

Table 61: Top three suggestions for being more strategically focused, by Aboriginal and Torres Strait Islander origin

| | Male | Female | Aboriginal | Not Aboriginal |
|---|---|---|---|---|
| **Topics** r | **42** | **96** | **7** | **130** |
| Engage with actual consumers/ lived experience/ treatment focussed | 36% | 32% | 43% | 34% |
| More collaboration/ engagement with stakeholders | 29% | 30% | - | 32% |
| Increased authority/ power/ scope | 17% | 13% | 14% | 14% |
| Whole of government approach | 12% | 8% | 14% | 9% |
| Standardised objectives & outcome frameworks/ accountability | 0%* | 9%* | 14% | 6% |
| Improved access to services/ service delivery | 5% | 4% | 14% | 4% |

Some examples of verbatim comments provided by respondents include:

ABORIGINAL AND TORRES STRAIT ISLANDERS:

> *"Listen to the community."* [Health professional]
>
> *"The MHC needs to be more than a statutory body. They need to be able to make organisations and systems accountable."* [Health professional]
>
> *"The Commission should be moved under Premier and Cabinet, rather than sitting under the Health portfolio."* [A person with lived experience of mental illness]
>
> *"Somehow aligning across all levels of government policies and measuring government outcomes, to make it more accountable."* [A family member or carer of a person with mental illness]
>
> *"The NDIS needs to be more accessible. They decline people in need who can't help themselves to challenge a wrong decision."* [A person with lived experience of mental illness]

Respondents born in Australia, who spoke a language other than English, were most diverse in their responses to this question about how the Commission could become more

strategically focused; however, this was largely due to the small sample in this CALD segment (n=7). The top three suggestions from each of the CALD groups are listed in Table 62.

Table 62: Top three suggestions for being more strategically focused, by culturally and linguistically diverse categories

| Topics | n= | Born in Australia, speaks English at home<br>90 | Born in Australia, speaks language other than English at home<br>7 | Born overseas, speaks English at home<br>26 | Born overseas, speaks language other than English at home<br>14 |
|---|---|---|---|---|---|
| Engage with actual consumers/ lived experience/ treatment focussed | | 33% | 29% | 35% | 36% |
| More collaboration/ engagement with stakeholders | | 30% | 14% | 31% | 36% |
| Increased authority/ power/ scope | | 13% | 14% | 23% | - |
| Whole of government approach | | 8% | 14% | 19% | - |
| Allocate funding more broadly/ equitably | | 6% | - | 8% | 14% |
| Standardised objectives & outcome frameworks/ accountability | | 7% | 29% | - | 7% |
| Raised profile | | 2% | 14% | 4% | - |
| Improved access to services/ service delivery | | 2% | 14% | 4% | 14% |

Some examples of verbatim comments provided by respondents include:

BORN IN AUSTRALIA, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

> *"I think there needs to be an increase in public awareness of the mental health system and mental health workers need to be more closely monitored. Mental health consumers should be encouraged to give regular feedback on services provided."* [A person with lived experience of mental illness]

*"More strongly link in with organisations that receive funding; making them more accountable in relation to consumer support and input."* [A family member or carer of a person with mental illness]

*"Support mental health workers."* [Health professional]

*"More resources."* [Other professional]

*"Promote a whole of government mental health approach, across the state."* [A person with lived experience of mental illness]

*"Increase the number of facilities/beds to assistance those in need to get the help they need, instead of leaving the community or private sector to do it at a profit."* [Member of the public (none of the above)]

BORN OVERSEAS, SPEAKS ENGLISH AT HOME:

*"The MHC possibly needs to engage in more depth with General Practice, for example, through the RACGP and ACRRM."* [Health professional]

*"There is duplication in the mental health system concerning a number of key priorities. There needs to be a state-wide reference group established, consisting of a wide representation of organisations … to ensure effective policy and evaluation outcomes."* [Health professional]

*"Be more aggressive within the health system and demand equity in access, quality and funding. The Commission should be more radical, while still embracing a health model."* [Health professional]

BORN OVERSEAS, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

*"The Commission needs to work from the ground up, and advocate for consumer wellbeing at all parts of the consumer journey within the health system."* [A person with lived experience of mental illness]

*"This is all just politics. No-one involves us. We need real help; not just stupid documents and blah-blah … We need help in our daily lives."* [A family member or carer of a person with mental illness]

*"Take into account the perspectives of health professionals and researchers, in addition to individuals with lived experience."* [Health professional]

*"More services to be made available. More budget to employ health workers, such as psychologists and social workers, across many agencies to support the growing numbers of people with mental illness."* [Health professional]

Respondents from major cities were the most likely to suggest that the Commission become more strategically focused (38%), while respondents from inner regional areas mentioned this significantly less often (13%).

Table 63: Top three suggestions for being more strategically focused, overall and by remoteness category

| Topics | Overall | Major cities | Inner regional | Outer regional/ remote |
|---|---|---|---|---|
| n= | 227 | 160 | 38 | 6 |
| More collaboration/ engagement with stakeholders | 33% | 38%* | 13%* | 33% |
| Engage with actual consumers/ lived experience/ treatment focussed | 27% | 26% | 37% | 17% |
| Whole of government approach | 14% | 14% | 8% | - |
| Increased authority/ power/ scope | 11% | 11% | 11% | 17% |
| Allocate funding more broadly/ equitably | 7% | 6% | 13% | 17% |
| Standardised objectives & outcome frameworks/ accountability | 8% | 6% | 13% | - |
| Improved access to services/ service delivery | 6% | 6% | 5% | 17% |

Some examples of verbatim comments provided by respondents include:

MAJOR CITIES:

> *"Engage further with NGOs and consumers to better inform the Commission's goals."* [NSW Health]
>
> *"I think one of the important things is actions, not just strategic plans. The Commission should be working harder at ensuring the government implements the strategic plans."* [A person with lived experience of mental illness]

INNER REGIONAL:

> *"Need to stop listening to the so-called experts, and engage with actual consumers."* [A person with lived experience of mental illness]
>
> *"Ask the front-line workers."* [Health professional]
>
> *"Focus on specific acute youth mental health services."* [NSW Health]

*"By presenting wide ranging annual report cards to Premiers, Parliament and the pubic, backed up by strong multi-sectoral data."* [Research/university sector]

OUTER REGIONAL/REMOTE:

*"Engage with stakeholders at the front line to debate the issues and how to fix them."* [Health professional]

*"Stronger advocacy back to Government."* [A family member or carer of a person with mental illness]

"*Look at the way services are funded. The competitive model encourages duplication and a lack of integration."* [Health professional]

*"Assessments having multiple categories to tick boxes."* [Mental health service provider or non-government organisation]

# 9 Future directions

Section 20 of the Act, which required the review of the Mental Health Commission after five years, to which this report is contributing, stipulates that the review will include an assessment of *whether the policy objectives of the Act remain valid and whether the terms of the Act remain appropriate for securing those objectives*. In reference to this, the online consultation sought feedback on what respondents considered most important for the Commission in the future.

## 9.1 Most important areas of focus for the future

The consultation questionnaire asked respondents to consider the existing functions of the Mental Health Commission (which were listed) and to rank the top three areas where they thought the Commission should focus in the future.

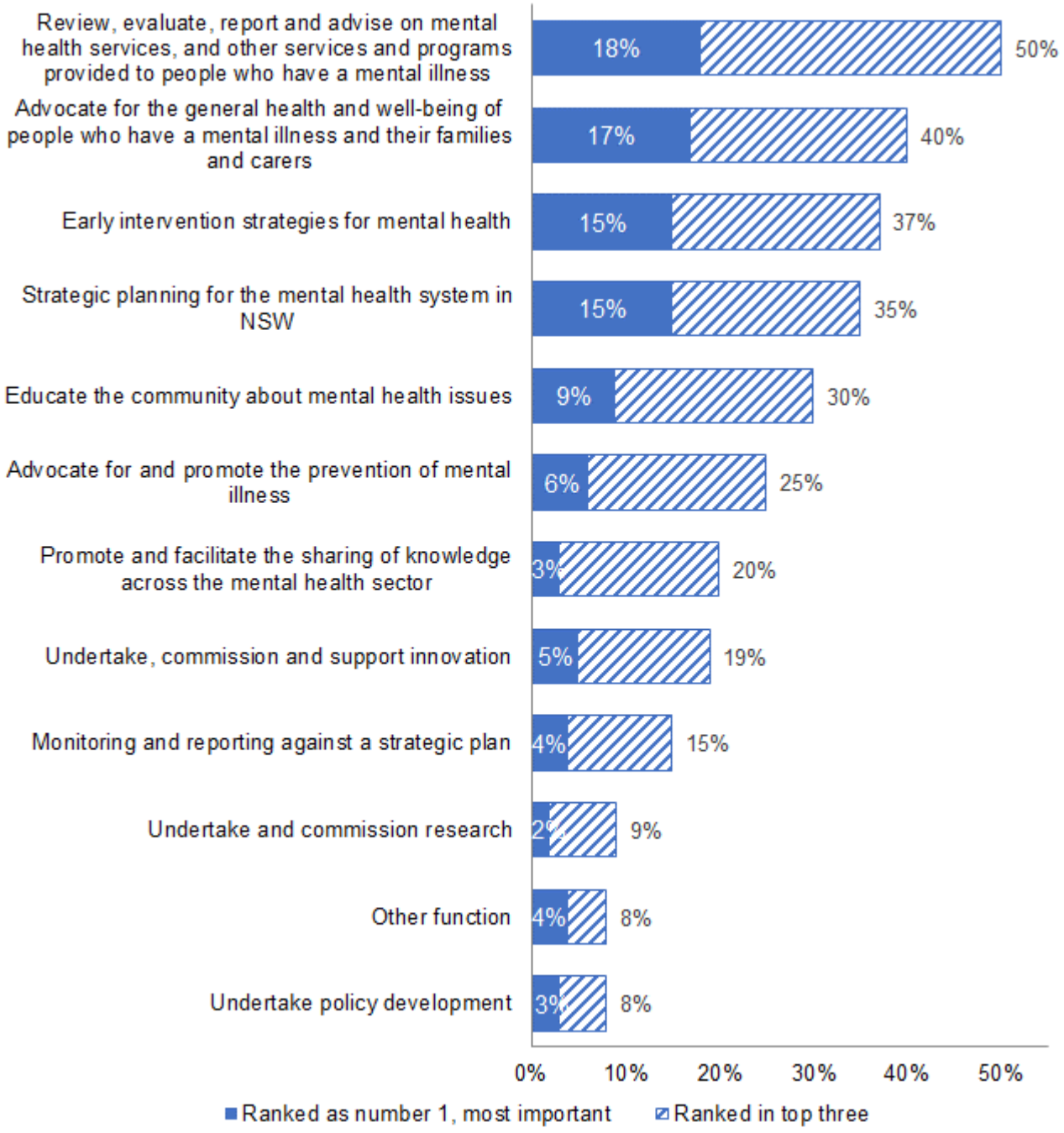
Figure 155 shows the prioritisation of the various functions, with the solid shading indicating the percentage of submissions which ranked it first; and the shaded section indicating the percentage who had ranked it in their top three.

The chart shows that the most important perceived priority for the Commission, ranked in the top three by one in two submissions (and first by one fifth), was the role of reviewing, evaluating and advising on mental health services (50% in top three; 18% as most important).

This was followed closely by an advocacy role (40% ranked this in the top three; and 17% first), early intervention strategies for mental health (37% and 15% respectively) and strategic planning for the mental health system in NSW (35% and 15% respectively).

Three in ten submissions indicated (in their top three) that the Commission should focus on educating the community around mental health issues (30%); and a quarter highlighted the importance of promoting the prevention of mental illness (25%).

Figure 155: Future function areas – areas ranked as most important, and in top three for importance, by respondents, overall (n=398)



The eight percent of respondents who had selected *Other function* for inclusion in their three most important future functions for the Mental Health commission were asked to specify what that other function would be. Some examples of the other functions specified by respondents included:

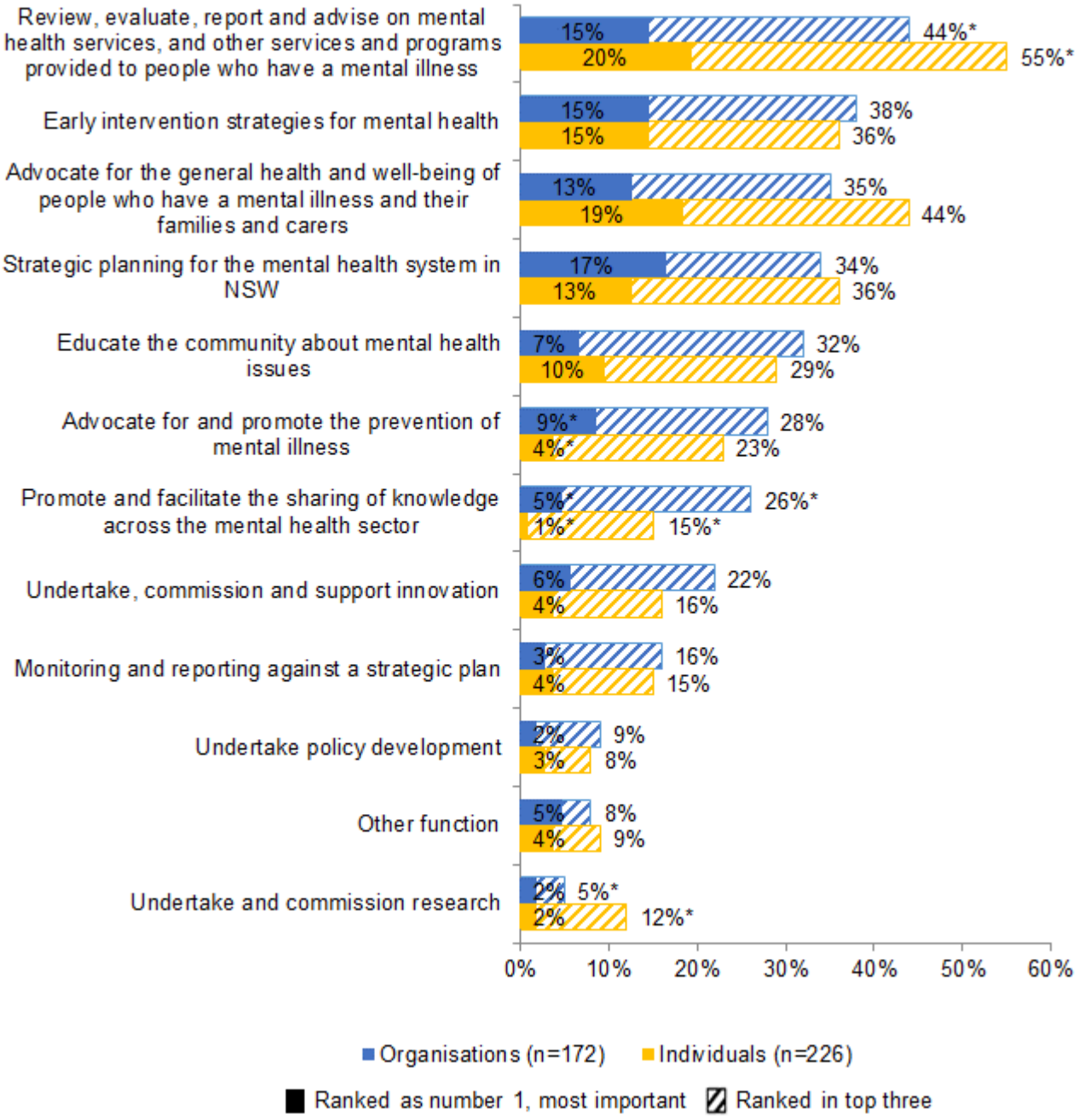
- Community/ lived experience engagement
- A focus on aged care
- *"Consult with actual suffers of mental health conditions and prepare a new plan given the impact of NDIS"*
- *"Focus on priority populations, including new and emerging CALD and refugee communities, and support existing CALD community organisations"*
- *"Promote and facilitate the sharing of knowledge across other government agencies"*
- *"We need to be sure that budget allocated to Mental Health Services is spent on Mental Health Services. The Commission must have the power to track the cash."*

Figure 156 shows all the consultation results separately for organisations and individuals. Organisations were significantly more likely to rank the review and advisory role in their top three (55% compared with 44% of individuals). They were also more likely to rank the importance of research in the top three (12% of organisations vs 5% of individuals).

Individuals, on the other hand, were significantly more likely to prioritise knowledge sharing (26% compared with 15% of organisations). All other differences shown were not statistically significant.

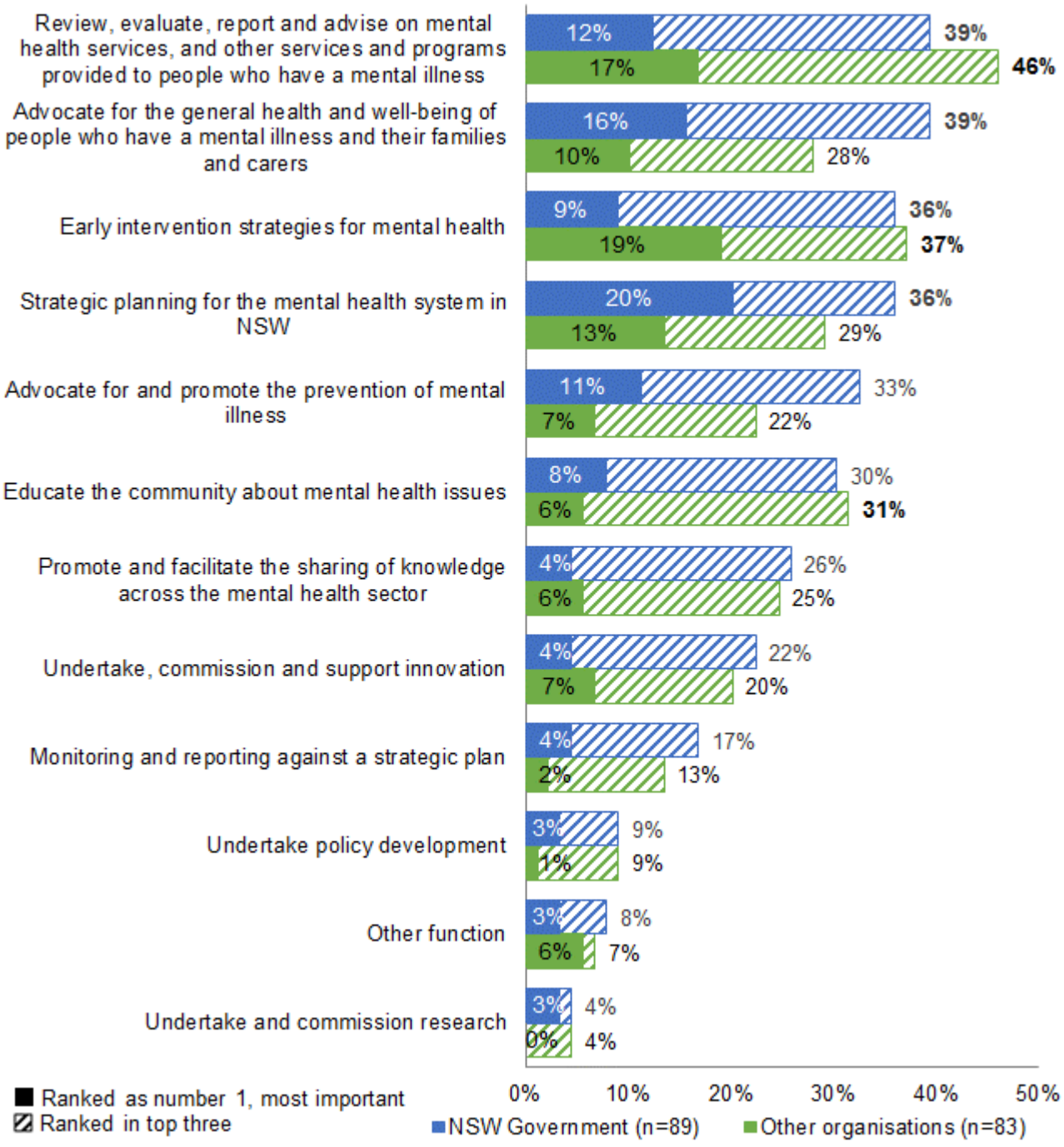
Figure 157 and Figure 158 show the all priority functions that high level organisations and high level individuals included as their highest ranked item, and in their top three. Of the four high level segments, people with lived experience of mental illness and their families and carers were particularly keen for the Commission to continue to prioritise reviewing, evaluating, reporting and advising on mental health services and programs provided to people who have a mental illness.

Figure 156: Future function areas – areas ranked as most important, and in top three for importance, by organisations and individuals (n=398)[20]




[20] All function areas are included in this graph. An asterisk indicates that the difference between the finding for the segment and the finding for respondents overall is statistically significantly.

Figure 157: Future function areas – areas ranked as most important, and in top three for importance, by high level organisation grouping (n=172)[21]




[21] All function areas are included in this graph. The bold data labels indicate the three areas that respondents from the particular segment most frequently included in their top three importance rankings.

Figure 158: Future function areas – areas ranked as most important, and in top three for importance, by high level individual grouping (n=226)[21]

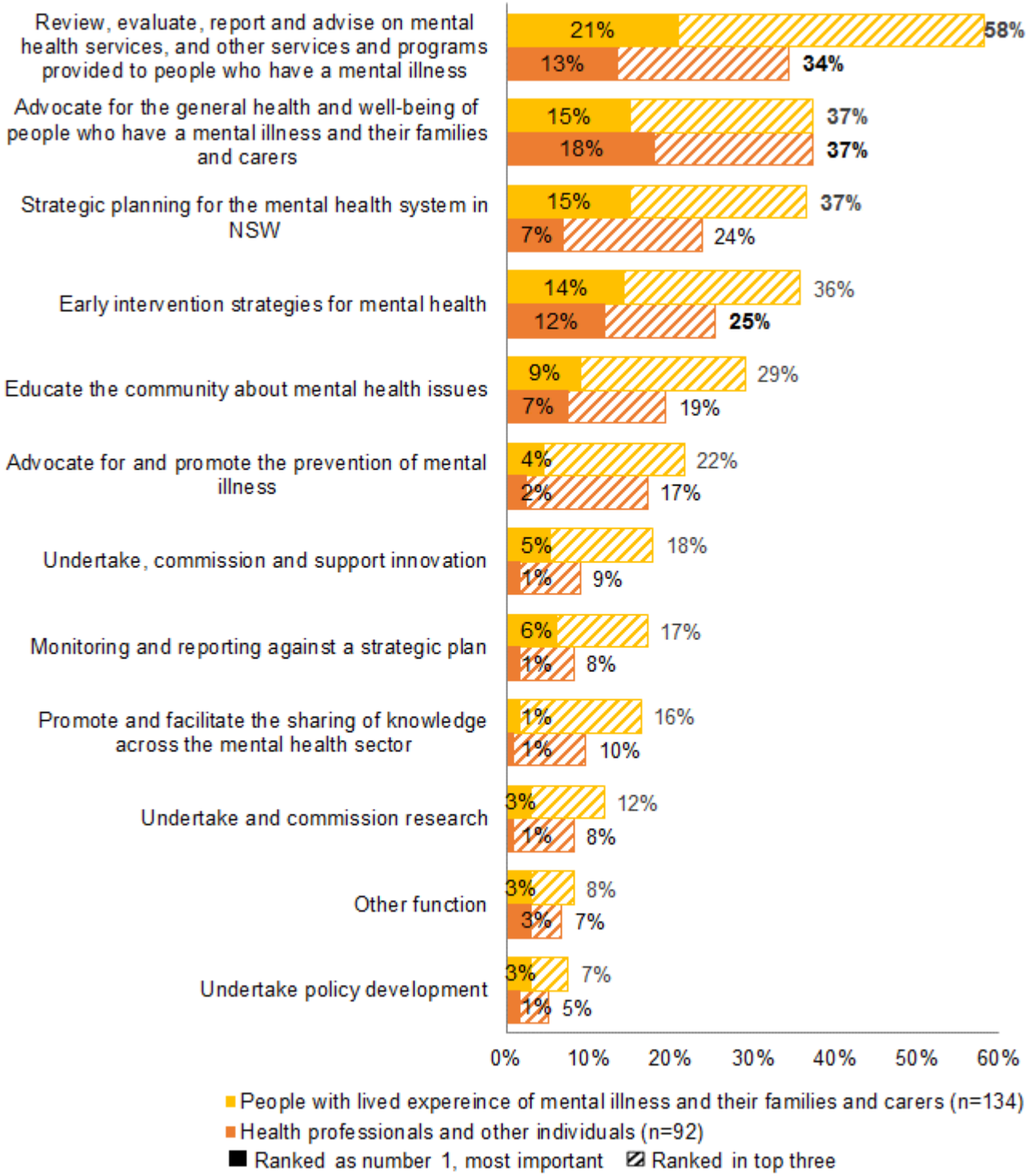
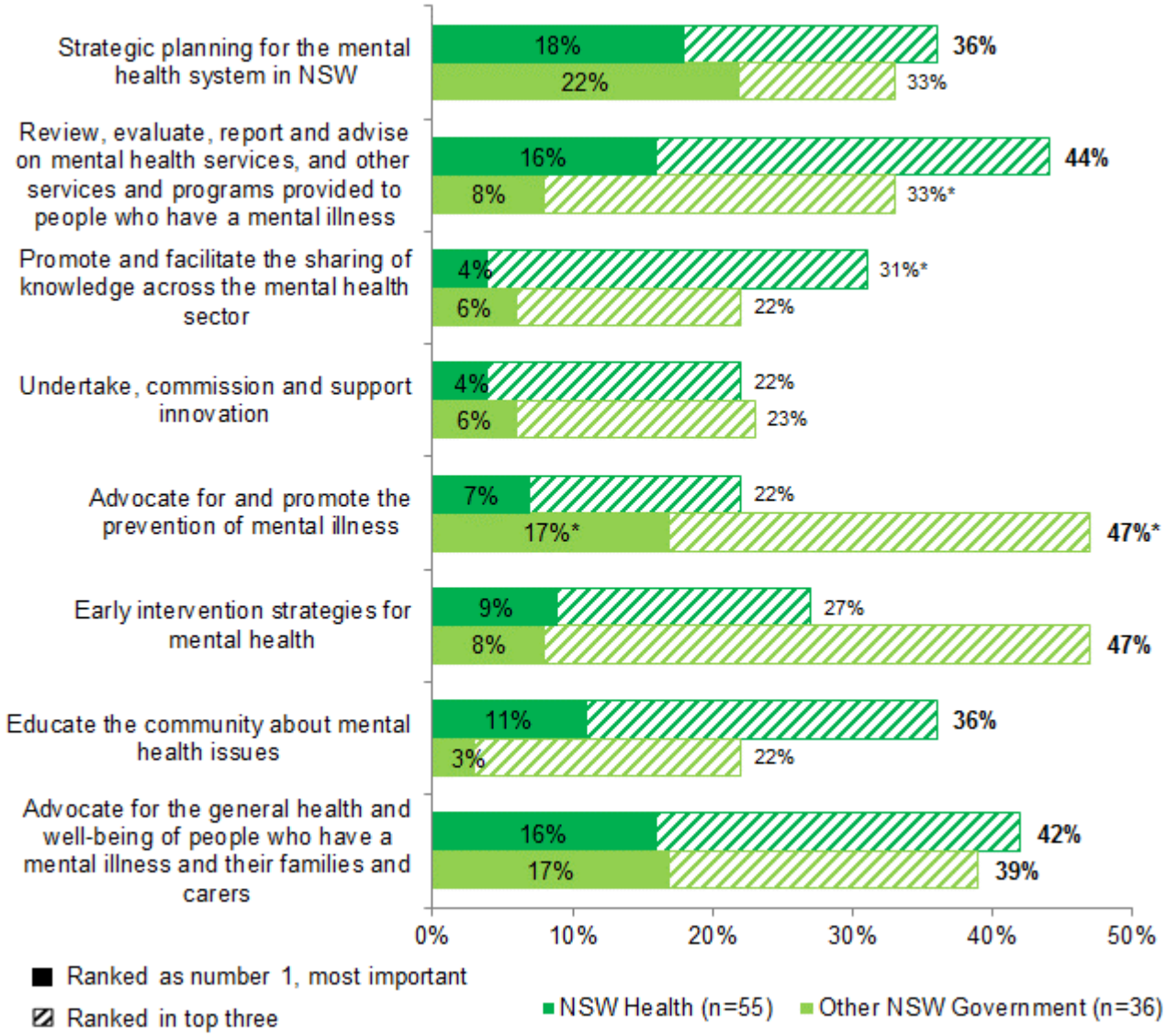


Figure 159 to Figure 164 show only the three future function areas that were most often included in the top three most important for each of the segments included in the graph.

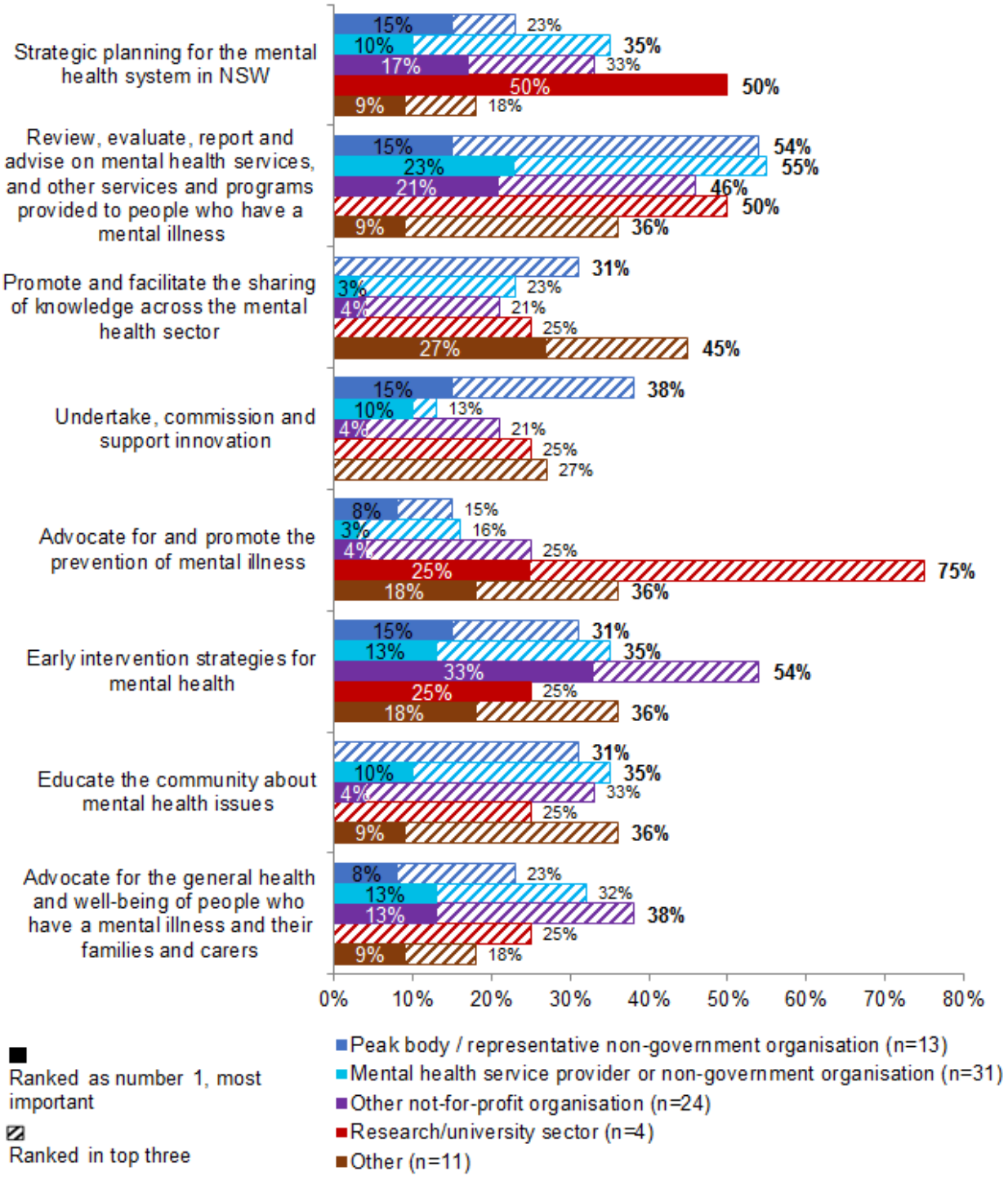
The only significant difference in the top three importance rankings for organisation types was that other NSW Government organisations more often included advocate for and promote the prevention of mental illness in their top three (47%), 17% even included it as the future function most important to them (compared to 9% of organisations overall). The top three future function areas for organisation types are shown in Figure 159 and Figure 160.

Figure 159: NSW Government organisations' three most important future function areas, by organisation type (n=89)[22, 23]




[22] Only the three function areas that were most frequently included in each segment's top three rankings of importance are included in this graph. The bold data labels indicate the three areas that respondents from the particular segment most frequently included in their top three importance rankings.
[23] An asterisk indicates that the difference between the finding for the segment and the finding for organisations overall is statistically significantly.

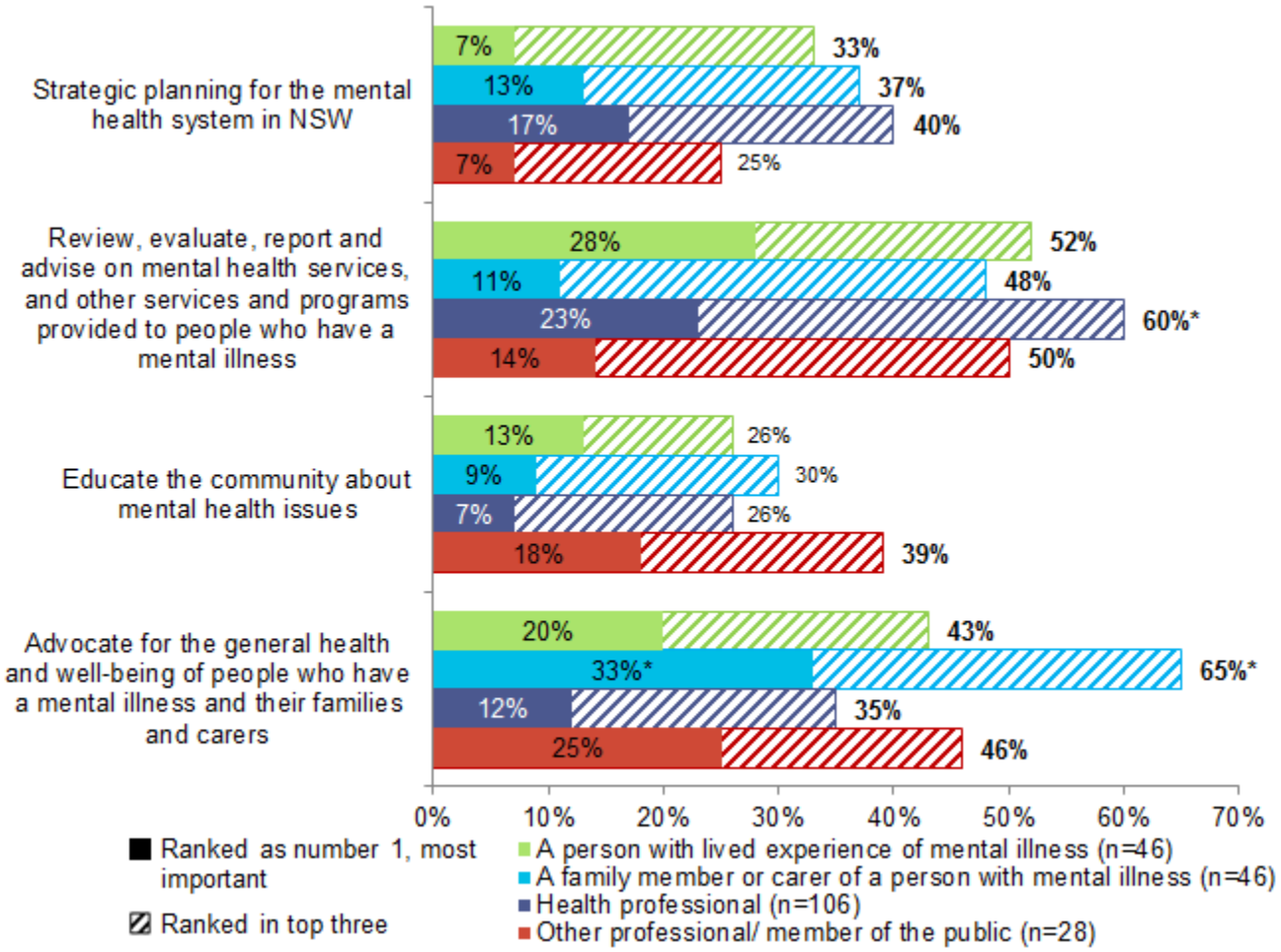
Figure 160: Other (non-government) organisations' three most important future function areas, by organisation type (n=83)[22, 24]




[24] An asterisk indicates that the difference between the finding for the segment and the finding for organisations overall is statistically significantly.

Individuals who worked as mental health professionals were significantly more likely to prioritise the Commission's function in terms of reviewing and advising on mental health services (60% compared with 55% of individuals overall). Family members and carers of individuals with mental illness were significantly more likely to rank the Commission's role in advocating for the general health of people with mental illness and their carers (65% compared with 44% of individuals overall).

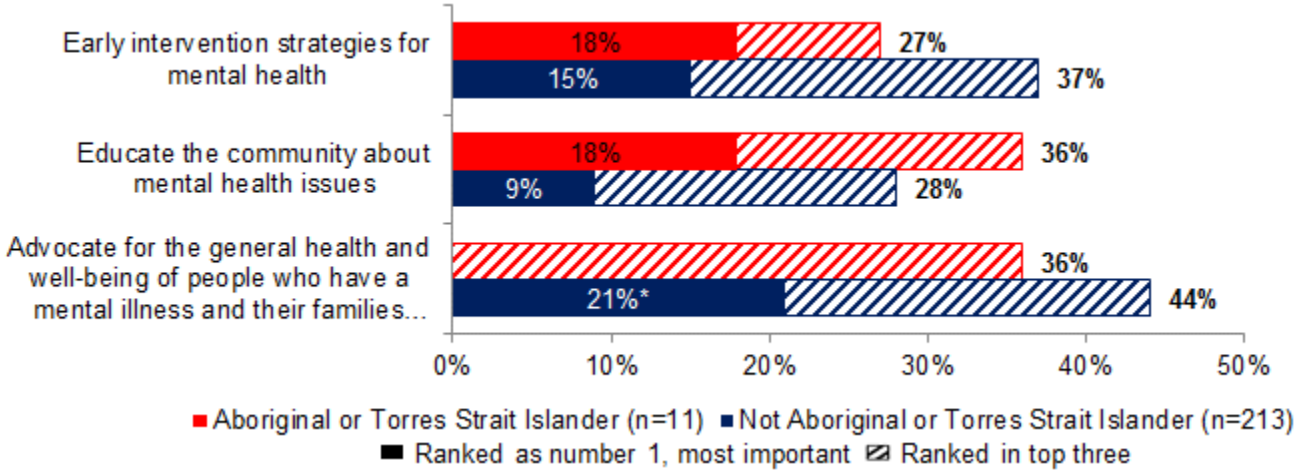
Figure 161: Individuals' top three most important future function areas, by individual background (n=226)[22, 25]




[25] An asterisk indicates that the difference between the finding for the segment and the finding for individuals overall is statistically significantly.

There were no significant differences between Aboriginal and non-Aboriginal respondents.

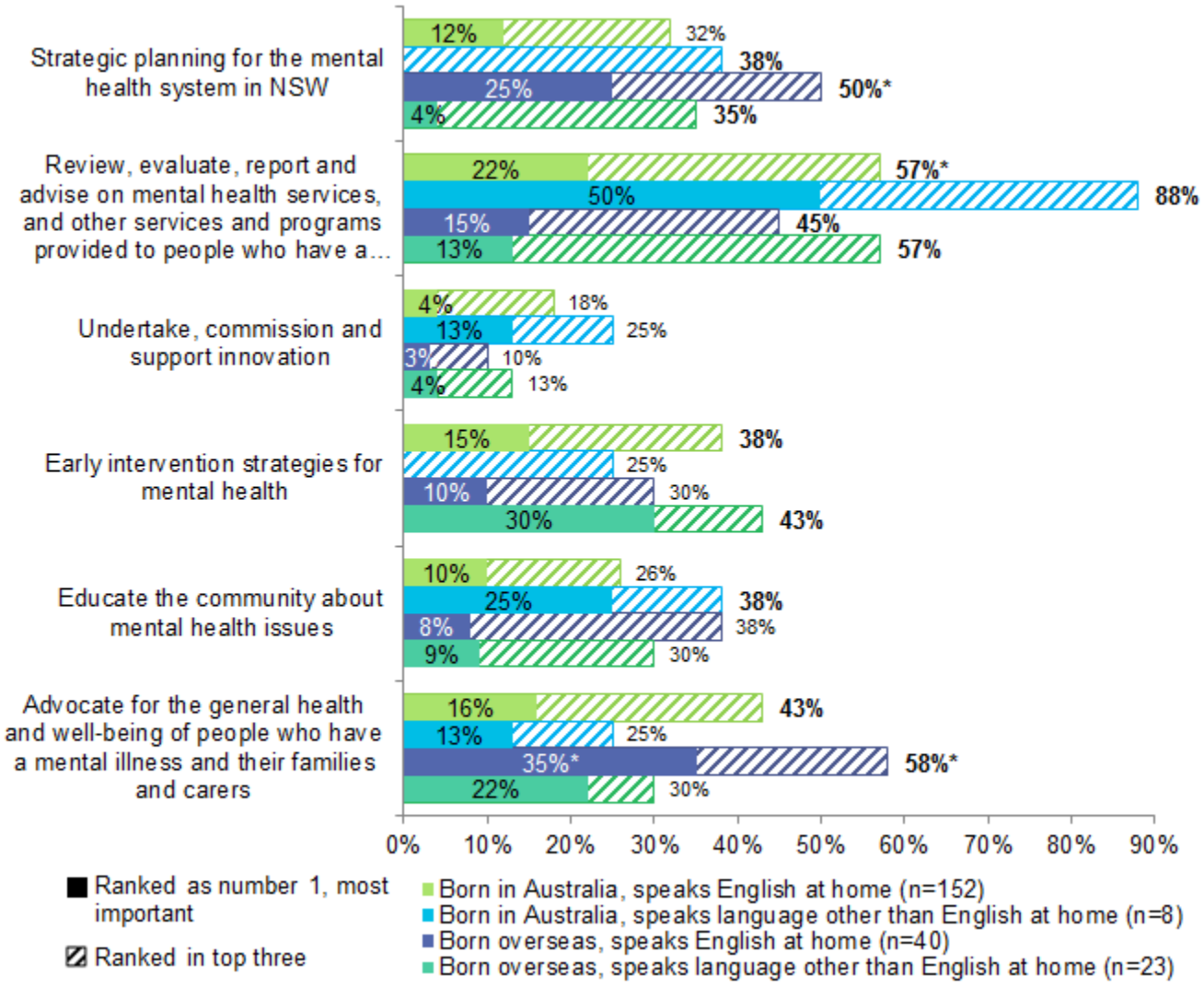
Figure 162: Top three most important future function areas, by Aboriginal and Torres Strait Islander origin (n=224)[22, 25]



Australian born individuals (who spoke only English at home) were significantly less likely (57%) to prioritise the importance of the Commission's review and advisory function (all other differences in this respect were not statistically significant).

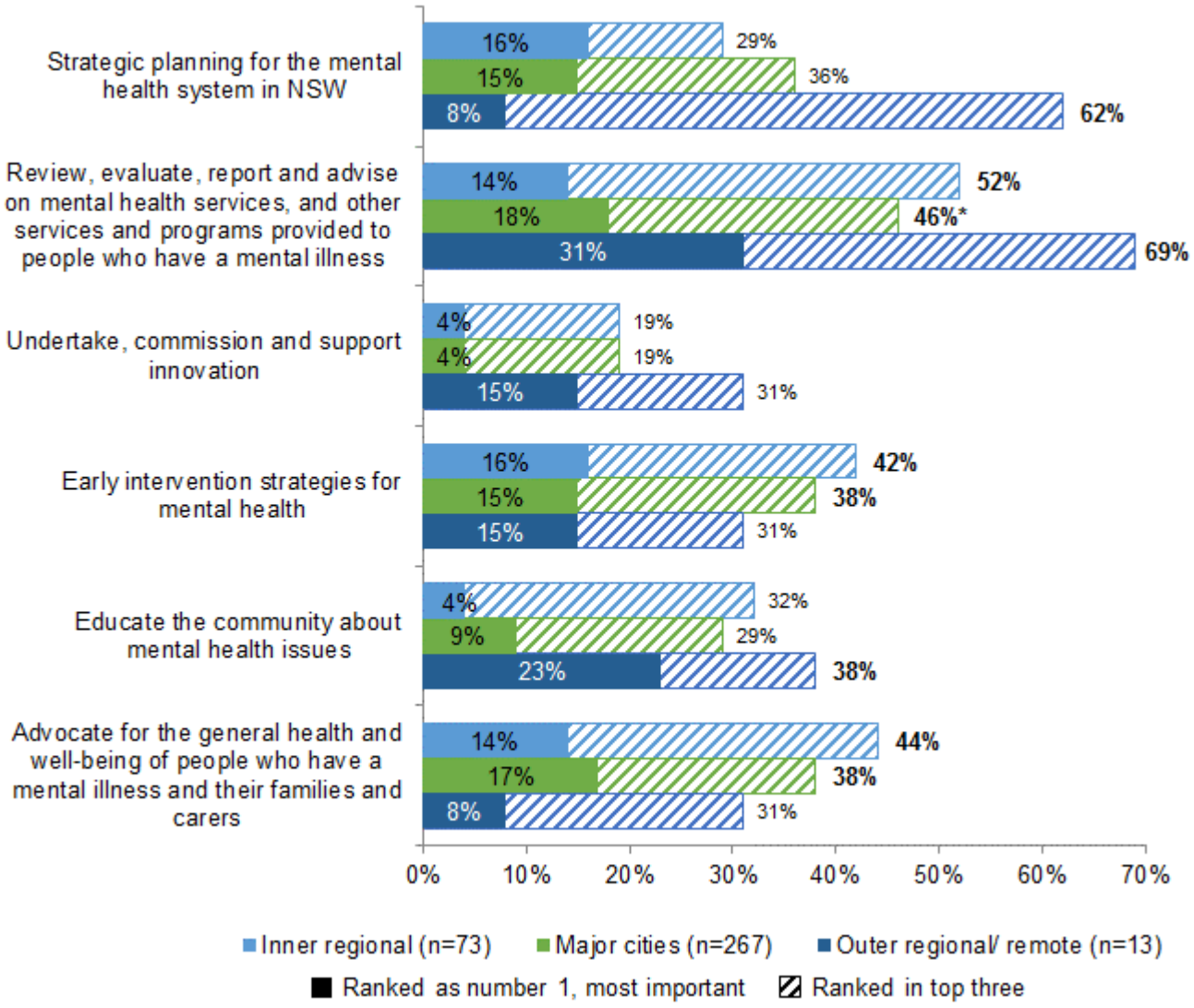
Those born overseas, who spoke only English at home, were significantly more likely to emphasise the advocacy function (58% compared with 44% of individuals overall) and the strategic planning role (50%, compared with 36% of individuals overall).

Figure 163: Top three most important future function areas, by culturally and linguistically diverse categories (n=223)[22, 25]



As shown in Figure 164, the only significant difference by remoteness category was that respondents from major cities were less likely to include reviewing, evaluating, reporting and advising in their selection of top three most important future functions.

Figure 164: Top three most important future function areas – areas ranked as most important, and in top three for importance, by respondents, by remoteness category (n=353)[22, 26]




[26] An asterisk indicates that the difference between the finding for the segment and the finding for respondents overall is statistically significantly.

## 9.2 Highest priority

Respondents were asked to state, in their own words, what they thought the highest priority should be for the Commission now, or in the near future.

The most important function was considered to be advocating for people with mental illness and ensuring adequate and quality support and care is provided to them (18%). Promoting and facilitating knowledge sharing, and monitoring, evaluating and reporting on services were also functions most frequently mentioned by respondents overall (both 12%).

Table 64: Top three comments about the highest priority, overall and by high level organisation and individual groupings

| Topics | n= | Overall 306 | NSW Government organisations 62 | Other organisations 60 | People with lived experience of mental illness and their families and carers 84 | Health professionals and other individuals 100 |
|---|---|---|---|---|---|---|
| More support/ advocacy for those with mental health problems | | 18% | 18% | 12% | 25% | 15% |
| Promoting and facilitating knowledge sharing | | 12% | 6% | 12% | 13% | 14% |
| Service reporting/ monitoring/ evaluation | | 12% | 13% | 12% | 8% | 15% |
| Whole of Government/ holistic/ collaborative approach | | 10% | 21% | 10% | 5% | 9% |
| Importance of/ focus on early intervention | | 8% | 15% | 8% | 7% | 6% |
| Quality of services provided | | 9% | 5% | 8% | 14% | 8% |
| Engaging with the community / more consumer rights/ engagement/ focus | | 9% | 6% | 12% | 10% | 10% |
| Outlining and pursuing a clear agenda - implementation/ innovation etc. | | 11% | 10% | 15% | 6% | 14% |
| Inequities/ equal access to MH services/ metro vs rural, specific groups, etc. | | 9% | - | 17% | 11% | 9% |

As in previous questions, organisations were significantly more likely than individuals to prioritise a collaboration right across the sector (16%).

NSW Health respondents, in particular, prioritised extra funding for mental health services (14%).

Peak bodies/ representative non-government organisations prioritised community engagement and the promotion and facilitation of knowledge sharing (27% each).

Table 65: Top three comments about the highest priority from organisations, overall and by organisation types

| Topics | n= | Organisations overall | Peak body / representative non-government orgs | Mental health service provider or non-gov org | NSW Health | Other NSW Government | Research/university sector | Other not-for-profit org | Other |
|---|---|---|---|---|---|---|---|---|---|
| | | 122 | 11 | 26 | 36 | 26 | 3 | 15 | 5 |
| Whole of Government/ holistic/ collaborative approach | | 16%* | 9% | 4% | 8% | 38% | 33% | 13% | 20% |
| More support/ advocacy for those with mental health problems | | 15% | 9% | 15% | 19% | 15% | - | 7% | 20% |
| Outlining and pursuing a clear agenda - implementation/ innovation etc. | | 12% | - | 19% | 11% | 8% | 33% | 13% | 20% |
| Service reporting/ monitoring/ evaluation | | 12% | 18% | 15% | 14% | 12% | - | 7% | - |
| Quality of services provided | | 7% | 9% | 12% | 6% | 4% | - | - | 20% |
| Funding/ resources | | 5% | - | - | 14%* | 4% | - | - | - |
| Engaging with the community / more consumer rights/ engagement/ focus | | 9% | 27% | 4% | 8% | 4% | - | 13% | 20% |
| Promoting and facilitating knowledge sharing | | 9% | 27% | - | 8% | 4% | 33% | 7% | 40% |
| NDIS issues | | 5% | 18% | 8% | - | 4% | - | 7% | - |
| Inequities/ equal access to MH services/ metro vs rural, specific groups, etc. | | 8% | 18% | 12% | 0%* | - | 33% | 20% | 20% |
| Importance of/ focus on early | | 11% | - | 8% | 11% | 19% | - | 20% | - |

| Topics | n= | Organisations overall | Peak body / representative non-government orgs | Mental health service provider or non-gov org | NSW Health | Other NSW Government | Research/university sector | Other not-for-profit org | Other |
|---|---|---|---|---|---|---|---|---|---|
| | | 122 | 11 | 26 | 36 | 26 | 3 | 15 | 5 |
| intervention | | | | | | | | | |

Some examples of verbatim comments provided by respondents include:

> *"Continue to lead a whole of government approach to mental illness."* [NSW Health]
>
> *"Advocacy for those with mental health conditions, and keep the needs of those experiencing a loss of mental wellbeing at the forefront of reform."* [Mental health service provider or non-government organisation]
>
> *"Examine consumers' priorities against government priorities. Develop a strategic plan that aligns these more effectively."* [Other]
>
> *"The Commission's highest priorities should be mental health strategic planning, implementation, monitoring and reporting. This should continue to be done in collaboration with a wide range of stakeholders, including people with lived mental health experience, other state government agencies, non-government organisations, clinicians, service providers, carers, and members of the community. The Commission is best placed to focus on this role given its independence, enabling it to work with a wide range of stakeholders and to facilitate different reform conversations."* [Other NSW Government]
>
> *"Focus on the vulnerable, please."* [Peak body / representative non-government organisation]

True to form, individuals thought the highest priority for the Commission was for it to provide support and advocate for people with mental health issues (20%). They also valued its promotion and facilitation of knowledge sharing, and monitoring, evaluating and reporting functions, with 14% and 12% respectively identifying these to be the Commission's highest priorities.

Respondents with a lived experience of mental illness had the significantly highest proportions of individuals who said that ensuring equal access to services for all people who needed them was of upmost importance (19%, compared to 2%-11% of other individuals), or that listening to, and involving people with lived experience should be the highest priority for the Commission (14%).

Families and carers often wanted the Commission to first focus on the quality of services (20%, compared to 5%-9% of other individuals).

Health professionals, on the other hand, wanted the Commission to set out a very clear and specific agenda, and pursue that agenda, to ensure that system-wide changes are made to mental health service delivery (16%).

Table 66: Top three comments about the highest priority from individuals, overall and by individual background

| Topics | n= | Individuals overall | A person with lived experience of mental illness | A family member or carer of a person with mental illness | Health professional | Other professional/ member of the public |
|---|---|---|---|---|---|---|
| | | 184 | 43 | 41 | 81 | 19 |
| More support/ advocacy for those with mental health problems | | 20% | 21% | 29% | 15% | 16% |
| Promoting and facilitating knowledge sharing | | 14% | 14% | 12% | 12% | 21% |
| Service reporting/ monitoring/ evaluation | | 12% | 5% | 12% | 16% | 11% |
| Quality of services provided | | 11% | 9% | 20%* | 9% | 5% |
| Outlining and pursuing a clear agenda - implementation/ innovation etc. | | 10% | 7% | 5% | 16%* | 5% |
| Inequities/ equal access to MH services/ metro vs rural, specific groups, etc. | | 10% | 19%* | 2% | 9% | 11% |
| Importance of/ focus on early intervention | | 7% | 5% | 10% | 4% | 16% |
| Importance of involving people with lived experience | | 5% | 14%* | 2% | 4% | - |

Some examples of verbatim comments provided by respondents include:

> *"More support for those with mental health problems to reduce suicide."* [A person with lived experience of mental illness]
>
> *"To reduce the stigma, continued education in relation to mental health in the wider community."* [Other professional]
>
> *"Reviewing what government agencies are actually doing in response to the Strategic Plan."* [Health professional]
>
> *"Better access to and provision of services."* [A family member or carer of a person with mental illness]
>
> *"Restructuring of the mental health service system."* [Health professional]
>
> *"Reform and reinvestment in a community-based, recovery-oriented mental health service system."* [Other professional]

Three of the eight Aboriginal respondents thought the Commission should prioritise its knowledge sharing promotion and facilitation activities (38%). (See Table 67.)

Table 67: Top three comments about the highest priority, by Aboriginal and Torres Strait Islander origin

| Topics | Aboriginal<br>n= 8 | Not Aboriginal<br>174 |
|---|---|---|
| More support/ advocacy for those with mental health problems | - | 20% |
| Outlining and pursuing a clear agenda - implementation/ innovation etc. | - | 11% |
| Promoting and facilitating knowledge sharing | 38% | 13% |
| Quality of services provided | 13% | 11% |
| Whole of Government/ holistic/ collaborative approach | 25% | 6% |
| Service reporting/ monitoring/ evaluation | - | 13% |
| Importance of/ focus on early intervention | 13% | 6% |
| Importance of involving people with lived experience | 13% | 5% |
| Reducing stigma/ discrimination | 13% | 2% |

Some examples of verbatim comments provided by respondents include:

ABORIGINAL AND TORRES STRAIT ISLANDERS:

> *"Normalising mental health issues as genuine medical conditions, in order to break down stigma and discrimination."* [A family member or carer of a person with mental illness]
>
> *"[The MHC needs to] talk to the community and explain their role in mental health, because at the moment, no-one knows, and they are a faceless organisation."* [Health professional]
>
> *"I think there needs to be an even stronger emphasis on cross-sector coordination and a whole of government and whole of community approach."* [A person with lived experience of mental illness]
>
> *"Better access and provision of services."* [A family member or carer of a person with mental illness]
>
> *"Early intervention for children/youth/young adults, especially those that have experienced complex trauma, to help mitigate the development of a severe mental illness and reduce the impact of trauma on overall mental health and wellbeing, as well as functioning."* [Health profession]
>
> *"Fix the mess we have now in NSW, by consulting with actual sufferers of mental health conditions."* [A person with lived experience of mental illness]

There were no stand-out differences between the priorities of the various CALD groups, taking into account their relative sample sizes. Respondents born overseas, who spoke a language other than English, had a slightly higher proportion who said that knowledge sharing promotion and facilitation should be prioritised by the Commission (27%, compared with 12%-16% of other CALD segments). (Refer to Table 68.)

Table 68: Top three comments about the highest priority, by culturally and linguistically diverse categories

| Topics | n= | Born in Australia, speaks English at home 129 | Born in Australia, speaks language other than English at home 6 | Born overseas, speaks English at home 32 | Born overseas, speaks language other than English at home 15 |
|---|---|---|---|---|---|
| More support/ advocacy for those with mental health problems | | 19% | 17% | 22% | 13% |
| Quality of services provided | | 12% | - | 9% | 13% |
| Outlining and pursuing a clear agenda - implementation/ innovation etc. | | 12% | 17% | 9% | - |
| Promoting and facilitating knowledge sharing | | 12% | 17% | 16% | 27% |
| Funding/ resources | | 5% | - | - | 13% |
| Engaging with the community / more consumer rights/ engagement/ focus | | 8% | 33% | 13% | 13% |
| Whole of Government/ holistic/ collaborative approach | | 7% | 17% | 9% | - |
| Service reporting/ monitoring/ evaluation | | 11% | - | 16% | 20% |
| Inequities/ equal access to MH services/ metro vs rural, specific groups, etc. | | 10% | 17% | 6% | 13% |
| Importance of/ focus on early intervention | | 5% | - | 6% | 13% |

Some examples of verbatim comments provided by respondents include:

BORN IN AUSTRALIA, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

> *"People with mental health issues/problems should be the focus. Assistance for carers."* [Member of the public (none of the above)]

*"Advocate for the wellbeing and care of people with a mental illness, their carers and families."* [Other professional]

*"Setting out an agenda, promoting that agenda, monitoring and reporting on how that agenda is going."* [A person with lived experience of mental illness]

*"More information of what is available to people with mental illnesses in all communities."* [A person with lived experience of mental illness]

*"Cross provider coordination."* [Health professional]

BORN OVERSEAS, SPEAKS ENGLISH AT HOME:

*"Addressing adverse outcomes from mental health issues."* [A family member or carer of a person with mental illness]

*"Inform, educate and advise the government regarding the facts about mental illness and recovery."* [Health professional]

*"Monitoring mental health system performance in NSW. Working to support Indigenous mental health in NSW."* [Other professional]

*"Improving in-patient and acute care services."* [Health professional]

*"Planning our NSW services for the next 5, 10 and 20 years, with a focus on quality of life and mental wellness."* [Health professional]

BORN OVERSEAS, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

*"Education of medical practitioners and the community."* [Other professional]

*"Identify a realistic timeframe to narrow the gap in services for Indigenous communities and measure the gains, or lack of them, every 12 months."* [Health professional]

*"Focus on how to stay well, good research and willingness to try new things. Please run trials of the Open Dialogue program here in Sydney. It will save people's lives."* [A family member or carer of a person with mental illness]

*"More funding for mental health care services, in order to address specific population needs."* [Health professional]

*"Advocacy, early intervention and primary prevention, research and provision of resources for the mental health sector."* [Other professional]

*"Focus on priority populations, because they are being left behind and are not accessing mental health services."* [A person with lived experience of mental illness]

Inner regional respondents were significantly more likely than those from other areas to stress the importance of mental illness prevention and early intervention (16%, compared with 0%-7% from other regions).

Outer regional/ remote respondents were more likely than others to say that the highest priority should be addressing current inequalities in consumer access to mental health services, by ensuring consistency in service provision, especially in rural areas (27%).

Table 69: Top three comments about the highest priority, overall and by remoteness category

| Topics | Overall n= 306 | Major cities 204 | Inner regional 56 | Outer regional/ remote 11 |
|---|---|---|---|---|
| More support/ advocacy for those with mental health problems | 18% | 20% | 14% | - |
| Promoting and facilitating knowledge sharing | 12% | 12% | 11% | 9% |
| Service reporting/ monitoring/ evaluation | 12% | 12% | 11% | 9% |
| Engaging with the community / more consumer rights/ engagement/ focus | 9% | 10% | 9% | 18% |
| Whole of Government/ holistic/ collaborative approach | 10% | 9% | 9% | 18% |
| Outlining and pursuing a clear agenda - implementation/ innovation etc. | 11% | 11% | 9% | 18% |
| Inequities/ equal access to MH services/ metro vs rural, specific groups, etc. | 9% | 8% | 5% | 27% |
| Importance of/ focus on early intervention | 8% | 7% | 16%* | - |

Some examples of verbatim comments provided by respondents include:

MAJOR CITIES:

> *"Advocacy for a fair deal for people with mental illness."* [Health professional]
>
> *"Education and advocacy."* [A family member or carer of a person with mental illness]
>
> *"Monitoring and reporting."* [Other professional]
>
> *"Review, evaluate and advise on Mental Health Services."* [Other not-for-profit organisation]

INNER REGIONAL:

*"The MHC should do whatever it can to encourage the training and support of many more nursing and allied health staff in the mental health system."* [Health professional]

*"Advocacy for more funding and more broader services."* [NSW Health]

*"Providing data to the public on the mental health of NSW citizens and key trends, including progress in suicide prevention."* [Research/university sector]

*"It's hard to say which is the highest priority: policies, planning and developing all should be a priority, but so should carer and client contact."* [A family member or carer of a person with mental illness]

*"Critically evaluate the services currently being delivered across all sectors and all levels of Government and private practitioners, hospitals and GPs."* [Health professional]

OUTER REGIONAL/REMOTE:

*"Accessibility to quality treatment / care."* [A person with lived experience of mental illness]

*"Better access to services and available beds … protection of staff, especially in rural areas of NSW. Also, timely help to all concerned"* [Health professional]

*"Working with those already in the mental health arena: consumers, their families, health workers and then the community."* [Health professional]

*"Ensuring the integration of services, so that people don't have so much difficulty navigating the choppy waters of service provision."* [Health professional]

*"Reform of the Mental Health Act to recognise psychological harm, then implement Mental Health Clinical Assessment Orders using the Mental Health Review Tribunal."* [A family member or carer of a person with mental illness]

# 10 Other comments from respondents

To end the online consultation survey, respondents were asked whether there were any other comments they would like to make about the role, functions or work of the Commission.

Respondents' feedback here often included comments on the "potential" of the Commission, but also on the current limitations on it being able to implement changes in practice, undermining its "actual influence." Almost a third were concerned that too much bureaucracy and policy was involved in mental health service provision, resulting in consumer needs not always being met, and their voices not always being heard (29%). As one respondent said, "policy is important but implementation is more important- if that fails, you fail the people that need our help the most."

Over a quarter of the submissions contained a "thank you" or commendation to the Commission for the "great job" it had done (26%).

Almost a fifth of respondents mentioned that they would like to see the Commission's role expanded, for it to develop additional or stronger relationships with other NSW and Commonwealth Government agencies, or be given additional power and resourcing (18%).

Table 70: Top three other comments, overall and by high level organisation and individual groupings

| Topics | n= | Overall 170 | NSW Government organisations 28 | Other organisations 31 | People with lived experience of mental illness and their families and carers 61 | Health professionals and other individuals 50 |
|---|---|---|---|---|---|---|
| Less bureaucratic/ more accessible/ user focussed | | 29% | 21% | 26% | 33% | 32% |
| General positive/ thanks | | 26% | 50% | 32% | 21% | 14% |
| More scope/ more coordination with other departments/ services | | 18% | 18% | 26% | 5% | 28% |
| More communication/ promotion of MHC's role | | 17% | 14% | 16% | 20% | 16% |
| Increased authority/ autonomy/ independence | | 6% | - | - | 3% | 16% |

Organisations were characteristically positive in their comments, and 41% expressed appreciation to the Commission for the work it had done. The exception to this trend was 'other' not-for-profit organisations, as only one of the nine expressed general thanks (11%), and others suggested ways to help improve mental health service accessibility for certain users, such as developing "strategies specifically targeting the needs of children and young people," or organising "education/workshop for CALD communities" and providing "language support" (33% of 'other' not-for-profit organisations, 24% of organisations overall).

A fifth of organisations wanted the Commissions role to be extended so that it is "more focused on transparency and accountability," saying it, "should be in a position to report in detail where the money has gone and what the outcomes are and provide an evaluation of those allocated funds" (22% of organisations overall).

Table 71: Top three other comments from organisations, overall and by organisation types

| Topics | n= | Organisations overall 59 | Peak body / representative non-government orgs 6 | Mental health service provider or non-gov org 11 | NSW Health 21 | Other NSW Government 7 | Research/university sector 2 | Other not-for-profit org 9 | Other 3 |
|---|---|---|---|---|---|---|---|---|---|
| General positive/ thanks | | 41%* | 33% | 18% | 52% | 43% | 100% | 11% | 100% |
| Less bureaucratic/ more accessible/ user focussed | | 24% | 33% | 27% | 24% | 14% | - | 33% | - |
| More scope/ more coordination with other departments/ services | | 22% | 33% | 36% | 10% | 43% | - | 22% | - |
| More communication/ promotion of MHC's role | | 15% | 17% | 18% | 19% | - | - | 22% | - |
| Funding concerns | | 5% | 17% | - | 5% | 14% | - | - | - |

Some examples of verbatim comments provided by respondents include:

> *"Thank you for the work you are doing."* [NSW Health]

*"Even if this Commission is not perfect as currently constituted, we are much better off for having this locus and focus for reform activities, research and support of principled innovation. We just need to make it better and more effective."* [Peak body / representative non-government organisation]

*"Please ensure consultation is with all mental health staff where possible; and as many consumers and carers as possible."* [NSW Health]

*"Need to advocate strongly to all government departments and push for funding."* [Other NSW Government]

*"The MHC really needs to become more visible to the CALD communities via their media and community organisations, especially in regional areas with high CALD populations."* [NSW Health]

Of the individuals from different backgrounds, significantly more health professionals wanted the Commission to become more integrated with other government departments, or even to bring some "international benchmarking" to the mental health sector (25%). They also more frequently mentioned a desire for the Commission to be given more authority or independence, or "greater levers to pull to influence change, bad practice and under-performance" (18%).

Table 72: Top three other comments from individuals, overall and by individual background

| Topics | n= | Individuals overall | A person with lived experience of mental illness | A family member or carer of a person with mental illness | Health professional | Other professional/ member of the public |
|---|---|---|---|---|---|---|
| | | 111 | 30 | 31 | 44 | 6 |
| Less bureaucratic/ more accessible/ user focussed | | 32% | 37% | 29% | 32% | 33% |
| More communication/ promotion of MHC's role | | 18% | 20% | 19% | 18% | - |
| General positive/ thanks | | 18%* | 17% | 26% | 14% | 17% |
| More scope/ more coordination with other departments/ services | | 15% | 3% | 6% | 25%* | 50% |
| Listen to those with lived experience of MH issues | | 10% | 20% | 10% | 5% | - |

| Topics | n= | Individuals overall 111 | A person with lived experience of mental illness 30 | A family member or carer of a person with mental illness 31 | Health professional 44 | Other professional/ member of the public 6 |
|---|---|---|---|---|---|---|
| Funding concerns | | 7% | 7% | 10% | 5% | 17% |
| Increased authority/ autonomy/ independence | | 9%* | 3% | 3% | 18%* | - |

Some examples of verbatim comments provided by respondents include:

> *"Make is simpler for consumers. Make it more accessible for regional/rural consumers."* [A person with lived experience of mental illness]
>
> *"The MHC is not visible enough."* [A family member or carer of a person with mental illness]
>
> *"I'd like to see more spreading of information about early intervention and services available to the public."* [A person with lived experience of mental illness]
>
> *"I personally think you are all doing a great job. The focus on community input is commendable. The Living Well report is a great read and very encouraging."* [Health professional]

Three of the six Aboriginal respondents thanked the Commission for the work it had done (50%).

Table 73: Top three other comments, by Aboriginal and Torres Strait Islander origin

| Topics | n= | Aboriginal 6 | Not Aboriginal 104 |
|---|---|---|---|
| Less bureaucratic/ more accessible/ user focussed | | 17% | 33% |
| Increased authority/ autonomy/ independence | | - | 10% |
| More scope/ more coordination with other departments/ services | | - | 16% |

| Topics | n= | Aboriginal 6 | Not Aboriginal 104 |
|---|---|---|---|
| More communication/ promotion of MHC's role | | 17% | 18% |
| General positive/ thanks | | 50% | 16% |

Some examples of verbatim comments provided by respondents include:

ABORIGINAL AND TORRES STRAIT ISLANDERS:

> *"Thank you John Feneley!"* [Health professional]
>
> *"The work of the Commission to date has raised awareness across communities and the sector."* [A family member or carer of a person with mental illness]
>
> *"We need to acknowledge that early treatment/intervention is the best factor and not to dismiss requests for intervention."* [Health professional]

Five of the nine respondents who were born overseas, and spoke a language other than English at home, commented that health services should be more accessible to all users, and that the mental health sector should be more focused on user needs (56%). Twenty percent (20%) to 35% of other CALD groups agreed.

Table 74: Top three other comments, by culturally and linguistically diverse categories

| Topics | n= | Born in Australia, speaks English at home 78 | Born in Australia, speaks language other than English at home 5 | Born overseas, speaks English at home 17 | Born overseas, speaks language other than English at home 9 |
|---|---|---|---|---|---|
| Less bureaucratic/ more accessible/ user focussed | | 29% | 20% | 35% | 56% |
| General positive/ thanks | | 19% | - | 12% | 33% |
| More communication/ promotion of | | 17% | 40% | 24% | 11% |

| Topics | n= | Born in Australia, speaks English at home | Born in Australia, speaks language other than English at home | Born overseas, speaks English at home | Born overseas, speaks language other than English at home |
|---|---|---|---|---|---|
| | | 78 | 5 | 17 | 9 |
| MHC's role | | | | | |
| More scope/ more coordination with other departments/ services | | 14% | 20% | 24% | - |
| Needs checks and balances/ regulation/ consumer rights protections/ complaints process | | 8% | 20% | 6% | 11% |
| Funding concerns | | 8% | - | 6% | 11% |
| Increased authority/ autonomy/ independence | | 8% | 20% | 18% | - |

Some examples of verbatim comments provided by respondents include:

BORN IN AUSTRALIA, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

*"Most people know very little about the MHC or what they do."* [Health professional]

*"Well done for a new organisation. Make the people working in the mental health system partners too, not the enemy. The enemy of us all is just an outdated system that needs to be busted up and switched around, so that the consumer is the director and the model is wellness and strengths."* [Health professional]

*"The Commission should be allowed to audit and report on services and programs."* [A person with lived experience of mental illness]

*"There needs to be some 'teeth' to the Commission; greater levers to pull to influence change, bad practice and under-performance."* [Health professional]

BORN OVERSEAS, SPEAKS ENGLISH AT HOME:

*"Provide more avenues for occupational, vocational and leisure activities."* [Health professional]

*"Strengthening policies and strategies to keep people out of hospital mental health units, which are still fearful places which disempower and often humiliate those who are placed there."* [A family member or carer of a person with mental illness]

*"The role and function of the MH Commission needs to more transparent, so that the community understands what the Commission does and what the NSW Mental Health Branch does!"* [Health professional]

*"I look forward to seeing the Ministry giving the MH Commission the full power and resources [it needs] to truly complete its role, functions and work."* [A family member or carer of a person with mental illness]

BORN OVERSEAS, SPEAKS LANGUAGE OTHER THAN ENGLISH AT HOME:

*"Thank you, things are better than in the 70's when my mum was sick. We must get the full required funding for mental health. It is unacceptable, horrific, that we let people with [a mental illness] diagnosis become homeless. We can do better still."* [A family member or carer of a person with mental illness]

*"Thank you for promoting and advocating for people living with mental illness."* [A family member or carer of a person with mental illness]

"*Please involve carers. I have no idea what the function of a Mental Health Commission is; I've never had any information. I have been a carer for five years and have never been asked a single question, nor been asked to be involved."* [A family member or carer of a person with mental illness]

*"The MHC needs to research the inside workings of programs before endorsing them superficially."* [A person with lived experience of mental illness]

One of the top three topics most often mentioned by respondents in inner regional and outer regional/ remote areas was a desire to receive more communication from the Commission, including information on its role and what its work "means to the coalface, what it means in practice" (13% of outer regional/ remote respondents, 21% of inner regional respondents).

Table 75: Top three other comments, overall and by remoteness category

| Topics | Overall | Major cities | Inner regional | Outer regional/ remote |
|---|---|---|---|---|
| n= | 170 | 111 | 28 | 8 |
| Less bureaucratic/ more accessible/ user focussed | 29% | 27% | 29% | 75% |
| General positive/ thanks | 26% | 30% | 18% | - |
| More scope/ more coordination with other departments/ services | 18% | 18% | 21% | - |
| More communication/ promotion of MHC's role | 17% | 14% | 21% | 13% |
| Needs checks and balances/ regulation/ consumer rights protections/ complaints process | 8% | 8% | 11% | 13% |
| Funding concerns | 6% | 8% | 4% | 13% |

Some examples of verbatim comments provided by respondents include:

MAJOR CITIES:

> *"John Feneley was an outstanding Commissioner. He was liked and respected across all sectors. His values of respect and commitment were exceptional and critical for the establishment and development of the Commission. These values are important for its continued success."* [Other]
>
> *"Keep up the good work!"* [Mental health service provider or non-government organisation]
>
> *"Their work needs to be more focussed on practicalities and ensuring that services are able to be accessed by those that need them, without them having to jump through hoops and beg." [A person with lived experience of mental illness]*
>
> *"They need better access to data - greater integration with other agencies working on the social determinants of health."* [Other professional]

INNER REGIONAL:

*"It is just another faceless organisation that is not relevant to daily life."* [A family member or carer of a person with mental illness]

*"More integration needed. Mental health promotion and prevention needs to be across all government departments."* [Health professional]

*"I am a nurse in the public health system, and apart from the knowledge that the Commission exists, I know nothing else about what it does. There needs to be more awareness of the Commission, of mental health issues in general, and what the work that the Commission does means to the coal face. What does it mean in practice?"* [Health professional]

OUTER REGIONAL/REMOTE:

*"Excellent report in 2014. The way it is implemented and applied to the person on the street is an issue, particularly in rural and remote areas."* [Mental health service provider or non-government organisation]

*"The MHC isn't set in stone and needs to be versatile to the needs of the community."* [Mental health service provider or non-government organisation]

*"I just wish we could see some benefit on the ground in remote communities. Nothing has changed really; we have services that come in and out and achieve nothing because they are not part of the community and change staff so often. How wonderful it would be to have funding to have a social work/general counsellor type person on the ground, living in each of our communities to really work with the communities to develop capacity and then refer on to specialist visiting services as needed."* [Health professional]

# Appendix A: Index of tables and figures

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# Appendix B: Questionnaire

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| NSW Mental Health Commission Review – Online survey<br>AU3000426<br>30 October 2017<br>NSW Health |

# Introduction

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

The Act required that a Review be undertaken after five years to consider whether the Commission has met the objectives of the Act, as well as its future roles and functions.

More information on the Review can be found here NSW Ministry of Health's website

The Ministry of Health now invites you to take part in the Review through this online consultation survey being conducted by independent research company, ORC International.

The Survey asks you to rate your level of agreement with statements and provides opportunities for further comment. Please limit each of your comments to no more than 300 words.

Not all questions may be relevant to your experience and if not, skip that question or answer don't know/prefer not to say.

The survey should take approximately 15 minutes to complete depending on the detail of your answers.

The survey is open until **5pm, Tuesday 7 November 2017**.

At any time during the survey, you can save your responses and return to them at a later time. Simply click the 'Save to return later' button located in the top right hand corner. You will be asked to provide an email address for a return link.

If you have any questions about this survey, please contact ORC International's support desk by clicking the 'Help' link within the survey.

If you have any questions about the review of the Mental Health Commission, please phone the Mental Health Branch, at the Ministry of Health, on 9461 7658, or email MHC_Review@doh.health.nsw.gov.au.

# Consent

C1. Your survey responses will be used by ORC International for research purposes only and no identifying details are needed. Results will be reported to the Ministry of Health in aggregate, and will be used to inform the Review of the Mental Health Commission.

ORC International will also make available to the Ministry the raw survey data, containing individual submissions in full and including any comments you make. This may be used by the Ministry to support additional analysis and reporting.

Do you consent to your complete response to this consultation survey, including any comments you may choose to provide, being provided to the Ministry of Health?

*(Note that if you change your mind, you are able to return to this question later, while completing the survey, and change your answer.)*

*Single response - please select one answer only*

| | |
|---|---|
| Yes, please make my full response data, including my unedited verbatim comments, available to the Ministry of Health | 1 |
| No, please only use my non-identifiable responses in aggregated reporting | 2 |

# Demographics

D1. We would first like to ask some questions about you and your organisation.

Are you taking part as an individual, or as a member of an organisation?

*Single response - please select one answer only*

| | |
|---|---|
| Organisation | 1 |
| Individual | 2 |

ANSWER IF D1 = 1 (Organisation)

D2. How would you describe your organisation?

*Please select one, main category only.*

| | |
|---|---|
| Peak body / representative non-government organisation | 1 |
| Mental health service provider or non-government organisation | 2 |
| Other not-for-profit organisation | 8 |
| NSW Health | 3 |
| Other NSW Government (Please specify) | 4 |
| Research/university sector | 6 |
| Other (Please specify) | 96 |

ANSWER IF D1 = 2 (Individual)

D3. How would you describe your individual background:

*Please select one, main category only.*

| | |
|---|---|
| A person with lived experience of mental illness | 1 |
| A family member or carer of a person with mental illness | 2 |
| Health professional | 3 |
| Other professional | 4 |
| Member of the public (none of the above) | 5 |

ANSWER IF D1 = 2 (Individual)

D4. Are you:

*Single response - please select one answer only*

| | |
|---|---|
| Male | 1 |
| Female | 2 |
| Other | 96 |
| Don't know/ Prefer not to answer | 99 |

ANSWER IF D1 = 2 (Individual)

D4A. Are you aged:

*Single response - please select one answer only*

| | |
|---|---|
| 24 or under | 1 |
| Over 24 years old | 2 |
| Don't know/ Prefer not to answer | 99 |

ANSWER IF D1 = 2 (Individual)

D5. Are you of Aboriginal or Torres Strait Islander origin?

*Single response - please select one answer only*

| | |
|---|---|
| Yes, Aboriginal | 1 |
| Yes, Torres Strait Islander | 2 |
| Yes, Aboriginal and Torres Strait Islander | 3 |
| No | 4 |
| Don't know/ Prefer not to answer | 99 |

ANSWER IF D1 = 2 (Individual)

D6. Do you speak a language other than English at home?

*Single response - please select one answer only*

| | |
|---|---|
| Yes | 1 |
| No | 2 |
| Don't know/ Prefer not to answer | 99 |

ANSWER IF D1 = 2 (Individual)

D6A. Were you born in Australia?

*Single response - please select one answer only*

| | |
|---|---|
| Yes | 1 |

| | |
|---|---|
| No | 2 |
| Don't know/ Prefer not to answer | 99 |

D7. What is your postcode?

_ _ _ _

☐ Prefer not to answer

# Functions under the Act

## 10.1 The strategic plan

Q1a. To what extent are you familiar with the work of the Mental Health Commission?

*Please rate the extent of your familiarity on a scale of 1 to 5, where 1 is 'Not at all' and 5 is 'Very'.*

| | | | | | | |
|---|---|---|---|---|---|---|
| Not at all<br>1 | 2 | 3 | 4 | Very<br>5 | | Don't know/ Prefer not to answer<br>99 |

Q1. The Mental Health Commission was required to prepare a draft **strategic plan** for the mental health system in New South Wales, and report on its implementation.

The plan *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024* was released in 2014.

The implementation report, *One Year On: Progress Report on the Implementation of Living Well*, was released in 2015.

To what extent do you agree or disagree with the following statements?

**The Mental Health Commission has...**

| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | | Don't know/ Prefer not to answer |
|---|---|---|---|---|---|---|---|---|
| A | Produced an effective strategic plan | 1 | 2 | 3 | 4 | 5 | | 99 |
| B | Sufficiently monitored and reported on the implementation of the Plan | 1 | 2 | 3 | 4 | 5 | | 99 |

ANSWER IF (Q1A OR Q1B) = (1 OR 2 OR 3 OR 4 OR 5) - Gave a rating

Q2. What do you think the impact of the strategic plan has been on the mental health system, and the mental health and wellbeing of the people of NSW?

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

## 10.2 Mental health services and programs

Q3. The Act also required the Mental Health Commission to review, evaluate, report and advise on mental health services and programs provided to people who have a mental illness, and other issues affecting people who have a mental illness.

Do you agree that the Mental Health Commission has effectively...

| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | | Don't know/ Prefer not to answer |
|---|---|---|---|---|---|---|---|---|
| A | Reviewed and evaluated mental health and other services, programs and issues | 1 | 2 | 3 | 4 | 5 | | 99 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| B | Reported and advised on mental health and other services, programs and issues | 1 | 2 | 3 | 4 | 5 | | 99 |

ANSWER IF (Q3A OR Q3B) = (4 OR 5) – Gave a rating of Agree or Strongly agree .

Q4. What do you think have been the most significant achievements of the Mental Health Commission in this regard?

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

IF ((Q3A or Q3B) = (1 OR 2 OR 3)) - Gave a rating of Disagree or Strongly disagree or Neither agree nor disagree.

Q4A. How could the Mental Health Commission more effectively focus this work?

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

## 10.3 Knowledge sharing

Q5. Do you agree or disagree that the Mental Health Commission has promoted and facilitated knowledge sharing about mental health issues in an effective way?

*Single response - please select one answer only*

| | |
|---|---|
| Strongly disagree | 1 |
| Disagree | 2 |
| Neither agree nor disagree | 3 |
| Agree | 4 |
| Strongly agree | 5 |
| Don't know/ Prefer not to answer | 99 |

IF Q5 = 1 OR 2 OR 3 OR 99 - Gave a rating of Disagree or Strongly disagree or Neither agree nor disagree OR Don't know/ Prefer not to answer)

Q6. What do you think the Mental Health Commission could do to further promote and facilitate the sharing of knowledge about mental health issues?

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

IF Q5 = 4 OR 5 – Gave a rating of Agree or Strongly agree .

Q7. Please provide one example, from your experience at any time during the *last five years* that best shows how the Mental Health Commission has promoted and facilitated sharing of knowledge about mental health issues.

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

# 10.4 Research and education

Q8. Do you agree or disagree that the Mental Health Commission has effectively undertaken...

| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | | Don't know/ Prefer not to answer |
|---|---|---|---|---|---|---|---|---|
| A | Research | 1 | 2 | 3 | 4 | 5 | | 99 |
| B | Innovation | 1 | 2 | 3 | 4 | 5 | | 99 |
| C | Policy development | 1 | 2 | 3 | 4 | 5 | | 99 |
| D | Initiatives to educate the community about mental health issues (including to reduce the stigma and discrimination) | 1 | 2 | 3 | 4 | 5 | | 99 |

ANSWER IF (Q8A OR Q8B OR Q8C OR Q8D) = (1 OR 2 OR 3 OR 4 OR 5) – Gave a rating

Q9. Please give an example of research, innovation, policy development, or an education initiative, that the Mental Health Commission has undertaken.

Briefly describe the impact that it had on the mental health sector or the mental health and wellbeing of the people of NSW.

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

## 10.5 Advocacy

Q10. Do you agree or disagree that the Mental Health Commission has effectively fulfilled its functions to advocate for and promote...

| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | | Don't know/ Prefer not to answer |
|---|---|---|---|---|---|---|---|---|
| A | The prevention of mental illness and early intervention strategies for mental health | 1 | 2 | 3 | 4 | 5 | | 99 |
| B | The general health and wellbeing of people who have a mental illness and their families | 1 | 2 | 3 | 4 | 5 | | 99 |

ANSWER IF (Q10A OR Q10B) = (1 OR 2 OR 3 OR 4 OR 5) – Gave a rating

Q11. What impact have the Mental Health Commission's advocacy and promotion activities had on the mental health sector or the mental health and wellbeing of the people of NSW?

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

# The Ministerial Charter letter of 2016

L1. The Ministerial Charter letter of 2016 identified a number of priorities for the Mental Health Commission for 2016-17.

Taking two of these, do you agree or disagree that the Mental Health Commission has effectively done the following...

| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | | Don't know/ Prefer not to answer |
|---|---|---|---|---|---|---|---|---|
| A | Ensured that the NDIS take appropriate account of the needs of people with psychosocial disability as a consequence of mental illness | 1 | 2 | 3 | 4 | 5 | | 99 |
| B | Developed innovative responses to the particular mental health and wellbeing needs of young people | 1 | 2 | 3 | 4 | 5 | | 99 |

# Operations

O1. Thinking about all the work done by the Mental Health Commission, since 2012, to what extent do you agree or disagree that it has...

| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | | Don't know/ Prefer not to answer |
|---|---|---|---|---|---|---|---|---|
| A | Focused on system wide mental health issues | 1 | 2 | 3 | 4 | 5 | | 99 |

O2. And, to what extent do you agree or disagree that its work has taken into account ...

| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | | Don't know/ Prefer not to answer |
|---|---|---|---|---|---|---|---|---|
| A | Co-morbidity (e.g. drug and alcohol, disability) | 1 | 2 | 3 | 4 | 5 | | 99 |
| B | The interaction between people who have a mental illness and the criminal justice system | 1 | 2 | 3 | 4 | 5 | | 99 |
| C | The needs of Aboriginal people and communities | 1 | 2 | 3 | 4 | 5 | | 99 |
| D | The needs of culturally and linguistically diverse communities | 1 | 2 | 3 | 4 | 5 | | 99 |
| E | The needs of regional and remote communities | 1 | 2 | 3 | 4 | 5 | | 99 |

O3. Do you agree or disagree that the Commission has effectively engaged and consulted with …

| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | | Don't know/ Prefer not to answer |
|---|---|---|---|---|---|---|---|---|
| A | People who have a mental illness | 1 | 2 | 3 | 4 | 5 | | 99 |
| B | Families and carers of people with a lived experience of mental illness | 1 | 2 | 3 | 4 | 5 | | 99 |
| C | NSW Government | 1 | 2 | 3 | 4 | 5 | | 99 |
| D | The non-Government sector | 1 | 2 | 3 | 4 | 5 | | 99 |
| E | The whole community | 1 | 2 | 3 | 4 | 5 | | 99 |

ANSWER IF O1 = (1 OR 2 OR 3 OR 4 OR 5) – Gave a rating

O4. Please give an example of how the Commission has successfully focused on system-wide mental health issues, and describe the impact of this.

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

# How the Commission has worked - Principles

P1. Please indicate your level of agreement with the following statement.

The Mental Health Commission works to the principles that people with mental illness should have access to the best possible care, are treated with dignity and respect, and are supported to live fully in community life and lead meaningful lives.

*Single response - please select one answer only*

| | |
|---|---|
| Strongly disagree | 1 |
| Disagree | 2 |
| Neither agree nor disagree | 3 |
| Agree | 4 |
| Strongly agree | 5 |
| Don't know/ Prefer not to answer | 99 |

P2. Do you agree or disagree that the Mental Health Commission has...

| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly Agree | | Don't know/ Prefer not to answer |
|---|---|---|---|---|---|---|---|---|
| A | Enhanced communication and collaboration with consumers, carers and stakeholders | 1 | 2 | 3 | 4 | 5 | | 99 |
| B | Operated from a *whole of government and whole of community* perspective | 1 | 2 | 3 | 4 | 5 | | 99 |
| C | Enhanced integration and coordination across the sector, including in the | 1 | 2 | 3 | 4 | 5 | | 99 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | areas of health, housing, employment, education and justice | | | | | | | |

P3. Do you think these principles (listed in the last two questions) should continue to underpin the Mental Health Commission's work, or are there any changes you think should be considered? If so, what?

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

ANSWER IF D2 = 3 OR 4 (NSW Government, NSW Health)

P4_Q1. To what extent do you agree or disagree that there is clarity of alignment between the work of the Commission and other NSW Government agencies?

*Single response - please select one answer only*

| | |
|---|---|
| Strongly disagree | 1 |
| Disagree | 2 |
| Neither agree nor disagree | 3 |
| Agree | 4 |

| | |
|---|---|
| Strongly agree | 5 |
| Don't know/ Prefer not to answer | 99 |

ANSWER IF D2 = 1 OR 2 OR 6 OR 8 OR 96 (Other organisations)

P5_Q1. To what extent do you agree or disagree that the work of the broader mental health system and the work of the Commission are clearly aligned?

*Single response - please select one answer only*

| | |
|---|---|
| Strongly disagree | 1 |
| Disagree | 2 |
| Neither agree nor disagree | 3 |
| Agree | 4 |
| Strongly agree | 5 |
| Don't know/ Prefer not to answer | 99 |

ASK ALL

P6_Q1 How might the work of the Commission be more strategically focused, in the context of the broader Government and mental health system?

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

# Future directions

F1. Considering the functions of the Mental Health Commission listed below, and your understanding of the broader Government, advocacy, research and service delivery context, what are the **three most important things** that the Commission can focus on in the future?

*Please circle one number only, in each column.*

| | Most important | 2nd most important | 3rd most important |
|---|---|---|---|
| Strategic planning for the mental health system in NSW | 1 | 1 | 1 |
| Monitoring and reporting against a strategic plan | 2 | 2 | 2 |
| Review, evaluate, report and advise on mental health, and other services and programs | 3 | 3 | 3 |
| Promote and facilitate the sharing of knowledge across the mental health sector | 4 | 4 | 4 |
| Undertake and commission research | 5 | 5 | 5 |
| Undertake, commission and support innovation | 6 | 6 | 6 |
| Undertake policy development | 7 | 7 | 7 |
| Advocate for and promote the prevention of mental illness | 8 | 8 | 8 |
| Early intervention strategies for mental health | 9 | 9 | 9 |
| Educate the community about mental health issues | 10 | 10 | 10 |
| Advocate for the general health and well-being of people who have a mental illness and their families and carers | 11 | 11 | 11 |
| Other function - please specify | 12 | 12 | 12 |

☐ Don't know/ Prefer not to answer

F2. What do you think should be the highest priority for the Commission now, or in the near future?

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

# Other comments

E1. Are there any other comments you would like to make about the role, functions or work of the Mental Health Commission?

*Please limit responses to 300 words or less*

☐ Don't know/ Prefer not to answer

# Thank and close

We appreciate you taking the time to respond to this consultation survey.

This research is being conducted in keeping with the Australian Privacy Principles and the industry Privacy Code.

ORC International's privacy policy is available on our website (www.orcinternational.com).

Thank you.

# APPENDIX 5
# MULTI-STAKEHOLDER FORUM OUTCOMES REPORT

# Multi-Stakeholder forum to inform the review of the Mental Health Commission of NSW:

## Report of outcomes

**Convening question:**

*What is the unique and impactful role that the Mental Health Commission can play to improve the mental health system and the mental health and wellbeing of the people of NSW?*

Compiled by:
Dr Leigh Gassner, Director
Nicole Endacott, Senior Consultant
Zoe Fitzgerald, Consultant
ReosPartners

"I am taking away optimism for the next ten more years

Participant at end of Forum

"I am taking away the sense of feeling heard, but wondering what will happen to all it."

Participant at end of Forum

"I am taking away people talking about feeling not heard and marginalised, and thank you for stopping to enable our voices heard – it was a beautiful thing/gesture."

Participant at end of the Forum

"I am taking away hope."

Participant at end of Forum

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## Executive Summary

On Tuesday, the 12th of December 2017 Reos Partners facilitated a multi-stakeholder collaborative forum to inform the statutory review of the NSW Mental Health Commission (MHC). The forum was attended by sixty participants from government and non-government including, peak bodies in the mental health sector. Also present were those with lived experience and carers.

The forum was part of the larger review being conducted by the team led by Dr David Chaplow. This includes a broad reaching survey of stakeholders across the health, mental health and government sectors; interviews and focus groups undertaken by the team; and a desktop review of submissions provided by key stakeholders to the review team. Some of this work was made available to Reos Partners to assist in designing the forum.

Among other deliverables including the design of the forum, Reos Partners was engaged to:

- Facilitate a one-day multi-stakeholder workshop (approximately sixty stakeholders), demonstrating a proven ability to effectively facilitate across diverse stakeholders and sensitive issues.
- Facilitate the delivery of innovative solutions and insightful opportunities for the future role, functions, principles and priorities for the Mental Health Commission, in the context of the broader system reforms necessary to deliver an effective mental health system that is well placed to meet the demands of the future.
- Provide a report on the outcomes of the workshop, which should include a one page conceptual framework on the future role, functions, principles and priorities for the Commission.

This report provides the results of the forum, including detailed insights and comments by the participants and also the analysis and identification of key themes that inform the future role, functions, principles and priorities. Finally, a one page conceptual framework on the future role, functions, principles and priorities for the commission is also provided.

A convening question was developed to resonate with stakeholders and provide an intent for them to focus their thinking and discussion. The convening question was:

*What is the unique and impactful role that the Mental Health Commission can play to improve the mental health system and the mental health and wellbeing of the people of NSW?*

The question was answered through initially understanding the ideal possible context or landscape in which the MHC could operate effectively. This was assisted by using the current 10 domains in *Living Well* document as a foundation to build that context.

From the context setting, the forum participants then identified functions the MHC could undertake, the level of involvement the MHC could take in performing those functions and where its effort should focus.

The high-level function areas identified were:

- Systems engagement and collaboration
- Community engagement
- Strategy
- Planning and monitoring
- Consumer/Carer outcomes
- Data collection and dissemination
- Promotion of innovation
- Independent voice
- Advocacy

A draft role statement was also developed by the participants:

***The Commission exists to provide - through the voice of lived experience - independent, systemic and strategic direction for the mental health and wellbeing of the people of NSW.***

Further, they identified priorities for the MHC, which are:

- To champion and advocate across the system the voices of those with lived experience that includes intentional inclusion and building a peer workforce.
- To ensure affordable equal and equitable (sic) access to mental health care.
- To ensure services are reviewed and evaluated and are consumer led, recovery focused, and outcome focused.

The functions, role and priorities were consolidated to build a conceptual framework at page 46. Time didn't allow deep inquiry into the principles. However, the facilitation team re-worded the present principles to more accurately represent the key insights and sentiment that emerged from the forum.

The functions reflected fundamental concerns the participants see in the system. One is the MHC having shared responsibility, or the need for collaboration in delivering its outcomes. A framework - possibly even one that is legislated - to assist in accountability for collaboration will be required. There are many ways legitimacy and accountability can be built, but it was seen as a critical requirement. This would need to be supported by the development of capabilities within the MHC that create generative and effective co-design and collaboration.

It was clear that participants felt that any function for the MHC should be at the strategic and system level. This could highlight what many participants felt is presently missing – an entity that keeps an eye on system outcomes as seen through the eyes of people with lived experience and - which the MHC is presently focusing on – addressing any disconnection in department/agency outputs.

A situation emerged during the forum that needs to be mentioned, as it underpins many of the insights and comments spoken of during the day and is consequently reflected in many aspects of this report. It was brought directly to the attention of the facilitation team, by representatives of consumers and carers, that some of them felt unsafe at the tables. So as to be clear as to the term 'unsafe' the team inquired further as to the exact concern. It appeared they meant discussion at some tables tended to be dominated by different individuals to the point that some consumers and carers felt they were not being heard and consequently felt shut out of discussion and what they wanted to contribute.

It will be seen throughout this report there is a strong need expressed for the voice of those with lived experience to be heard in developing policy, co-designing the system, implementation and evaluation. One manner of interpreting this concern is that what was happening is indicative of the frustration some consumers and carers feel with the larger system. Nevertheless hearing, and ensuring, others hear the voice of those with lived experience was seen as an important unique and impactful contribution the MHC.

The contributions throughout the forum in identifying the role, functions, priorities are reflected in the development of a one page conceptual framework.

The framework relies on an analysis and synthesis of the insights and contributions that emerged from the forum. It also has some **bolded** words, which emphasise some of the language used in providing the insights - in other words to show a direct line of sight to what emerged. In the Role Statement, we have included a reference to the voice of lived experience in recognition of what can be regarded as the most *unique and impactful* contribution the MHC can make.

Finally, due to the shortage of time in the forum the principles were not fully covered. This was foreseen as a possibility and, in discussing this with the review team, it was decided that the role, functions and priorities were the key outcomes to deliver. The present principles have been looked at and, even though still considered relevant, some suggested changes and/or additions which make them more aligned to the contributions from the forum. These are in red in the conceptual framework below.

# Review of the New South Wales Mental Health Commission
# Forum held on 12th December 2017

## Introduction

On Tuesday, the 12th of December 2017, Reos Partners facilitated a multi-stakeholder collaborative forum to inform the statutory review of the NSW Mental Health Commission (MHC). The forum was attended by sixty participants including those with lived experience and their carers, and representatives from government and non-government organisations including peak bodies in the mental health sector.

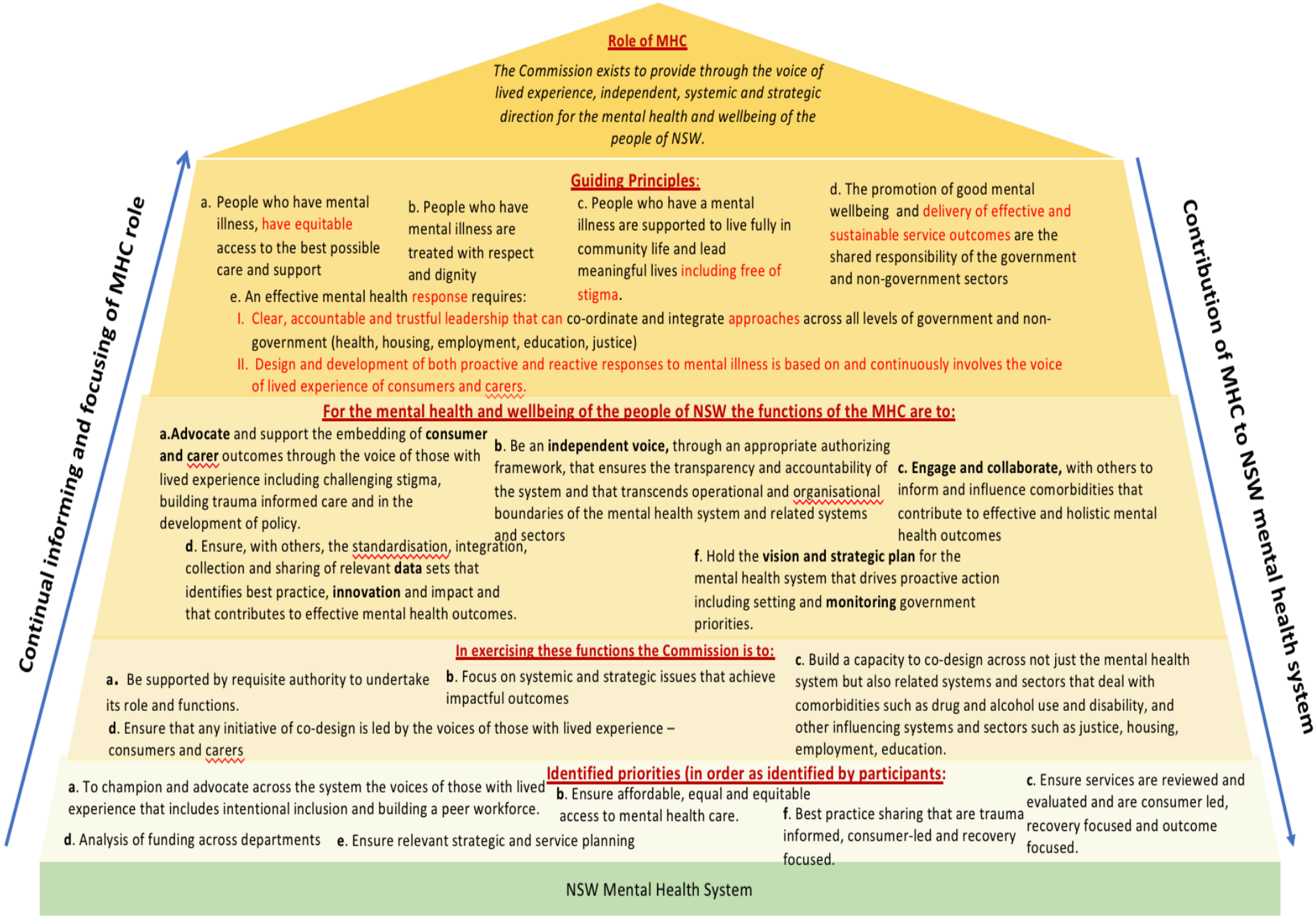
The forum was part of the statutory review being conducted by the team led by Dr David Chaplow which includes a broad reaching survey of stakeholders across the health, mental health and government sectors; interviews and focus groups undertaken by the team; and a desktop review of submissions provided by key stakeholders. Some of this work was made available to Reos Partners to assist in designing the forum.

Reos Partners was engaged to:

- Facilitate a one-day multi-stakeholder workshop (approximately sixty stakeholders), demonstrating a proven ability to effectively facilitate across diverse stakeholders and sensitive issues.
- Facilitate the delivery of innovative solutions and insightful opportunities for the future role, functions, principles and priorities for the Mental Health Commission, in the context of the broader system reforms necessary to deliver an effective mental health system that is well placed to meet the demands of the future.
- Provide a report on the outcomes of the workshop, which should include a one-page conceptual framework on the future role, functions, principles and priorities for the Commission.

This report provides the results of the forum, including detailed insights and comments by the sixty participants and analysis and identification of key themes that will inform the Commission's future role, functions, principles and priorities. Finally, a one-page conceptual framework on the future role, functions, principles and priorities for the Commission is also provided.

To commence the design of the forum, Reos Partners proposed a process to assist the facilitators understand the operating landscape or context of the Mental Health Commission. An overview of the process design for the forum is at Appendix 'A'.


Role of MHC
The Commission exists to provide through the voice of lived experience, independent, systemic and strategic direction for the mental health and wellbeing of the people of NSW.
Guiding Principles:
a. People who have mental illness, have equitable access to the best possible care and support
b. People who have mental illness are treated with respect and dignity
c. People who have a mental illness are supported to live fully in community life and lead meaningful lives including free of stigma.
d. The promotion of good mental wellbeing and delivery of effective and sustainable service outcomes are the shared responsibility of the government and non-government sectors
e. An effective mental health response requires:
I. Clear, accountable and trustful leadership that can co-ordinate and integrate approaches across all levels of government and non-government (health, housing, employment, education, justice)
II. Design and development of both proactive and reactive responses to mental illness is based on and continuously involves the voice of lived experience of consumers and carers.
For the mental health and wellbeing of the people of NSW the functions of the MHC are to:
a.Advocate and support the embedding of consumer and carer outcomes through the voice of those with lived experience including challenging stigma, building trauma informed care and in the development of policy.
b. Be an independent voice, through an appropriate authorizing framework, that ensures the transparency and accountability of the system and that transcends operational and organisational boundaries of the mental health system and related systems and sectors
c. Engage and collaborate, with others to inform and influence comorbidities that contribute to effective and holistic mental health outcomes
d. Ensure, with others, the standardisation, integration, collection and sharing of relevant data sets that identifies best practice, innovation and impact and that contributes to effective mental health outcomes.
f. Hold the vision and strategic plan for the mental health system that drives proactive action including setting and monitoring government priorities.
In exercising these functions the Commission is to:
a. Be supported by requisite authority to undertake its role and functions.
b. Focus on systemic and strategic issues that achieve impactful outcomes
c. Build a capacity to co-design across not just the mental health system but also related systems and sectors that deal with comorbidities such as drug and alcohol use and disability, and other influencing systems and sectors such as justice, housing, employment, education.
d. Ensure that any initiative of co-design is led by the voices of those with lived experience – consumers and carers
Identified priorities (in order as identified by participants:
a. To champion and advocate across the system the voices of those with lived experience that includes intentional inclusion and building a peer workforce.
b. Ensure affordable, equal and equitable access to mental health care.
c. Ensure services are reviewed and evaluated and are consumer led, recovery focused and outcome focused.
d. Analysis of funding across departments
e. Ensure relevant strategic and service planning
f. Best practice sharing that are trauma informed, consumer-led and recovery focused.
NSW Mental Health System
Continual informing and focusing of MHC role
Contribution of MHC to NSW mental health system

## Forum Process and Outcomes

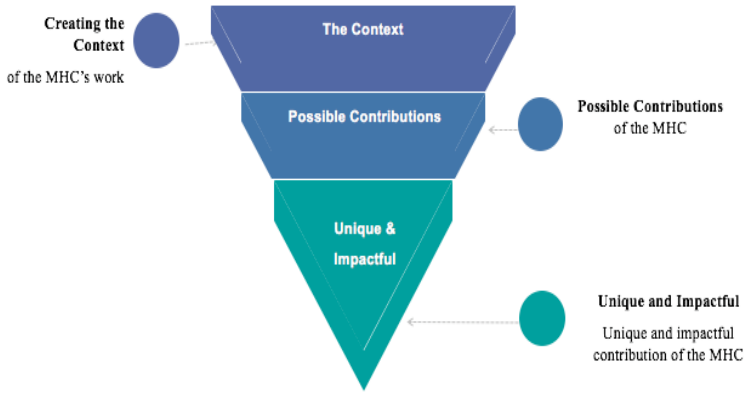
### Welcome, introduction and flow

Dr David Chaplow provided a welcome and introduction for the participants. Importantly, Dr Chaplow stressed the context of the day, that it was one part of a larger review process already being undertaken by the review team.

The facilitation team then introduced themselves and went through the desired outcome and flow of the day. This was described as being able to hear the thoughts of those present in regard to the convening question, recognising that before being able to focus on the role, functions and priorities, it would be necessary to understand the present and desired future context of the MHC. It was also impressed that the intention wasn't to develop a 'shopping list' but to understand the key inputs into:

- A **role**: purpose of **why** the MHC exists
- The **functions**: what are the main activities of the MHC
- The **priorities**: focus areas within or across the key functions

The flow of the day is diagrammatically depicted as:




### Check-in: *Who is in the room?*

With sixty people in the room the facilitators conducted a 'check-in' process whereby the participants introducing themselves to different people in the room. A check-in assists participants in connecting and being present to themselves, to each other and the topic at hand. The facilitators were also

aware that one of the important outputs of these events is to connect, speak and network with each other. The process asked the participants to engage with each other, through asking the following questions:

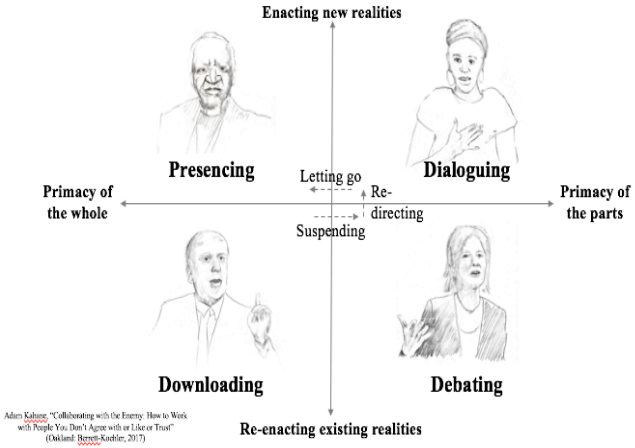
- How are you feeling today?  What part of you wants to be here?
- Is there any part of you that doesn't want to be here? Which part is that and what do you need for that part to "come along"?
- What do you find challenging and what do you find rewarding about being in the mental health space?
- How do you want to be leaving here today?

Each person was able to talk to at least four others through this process.

## Listening and Talking: *Building a safe generative space*

Reos Partners encourages participants in workshops or forums to listen and talk in a manner that is generative, moves the discussion forward, respects the perspectives and viewpoints of others, yet doesn't create stuck discussions. Accordingly, the facilitators spent time on a model called the four ways of listening and talking. It allows participants to move from downloading and debating which can cause cyclic discussions that don't move forward, to dialogue and presencing – that is, holding one's perspectives and views lightly, in a way that allows others to be heard. This is more likely to generate the collective insights necessary to achieve the desired outcomes of the Forum.

The issue of how the group worked together became critical later in the day and will be specifically focussed on in this report. The four ways are depicted here.




## Paired Dialogue Walk: *What we know so far*

In recognition that the participants would be coming to the forum with preconceived notions and perspectives - built from experience through previous ways of operating and interacting - it was decided to give time to allow them to voice these notions and perspectives It was designed to do this in a manner that allowed the participants to glimpse in the rear vision mirror but in the context of what will assist them to collectively move forward.

A paired dialogue walk is where participants, preferably find someone they don't often work or interact with and share insights from their experiences that would assist the discussion. They were asked to spend time walking with that person then return to tables and discuss what came up in the paired walk. To assist in their dialogue, participants were asked to answer two questions:

*"When thinking about the mental health and wellbeing of the people of NSW:*

1. *When you look in the rear vision mirror, what do you see?"*
2. *When you look through the front windscreen, what do you see on the horizon?"*

At their tables, participants shared what emerged and each table was asked to provide three key insights. The insights are provided below. These insights have been placed under each of the questions asked, but it is pointed out that some insights could sit in either of the columns. For example, an insight for going forward is possibly borne from what was observed from the past. It should also be noted that terminology used below is verbatim from what participants wrote and not changed.

| *When you look in the rear vision mirror, what do you see?* | *When you look through the front windscreen, what do you see on the horizon?* |
|---|---|
| • Stagnation => innovation (not there yet)<br>• Stigma and discrimination still occurring<br>• Broken down recovery buses! (choice; person's journey) Some of the recovery buses are wrecks; need sign posts by people with lived experience; person chooses who is on their bus and are they the driver or do they want to select someone else at this time; disconnect from knowledge -> practice of trauma informed care and recovery focused practice.<br>• Be optimistic about what works<br>• Looking back – uncluttered – less choices<br>• Voice of the consumer was minimal in the past<br>• The 'where' has shifted (much more in the community, not enough) but the 'what' has not changed significantly<br>• Accessing effective support – competency; capability for broader service system (schools, workforce)<br>• Being value/able to seek support – stigma; community dialogue is improving<br>• Fragmentation and lack of coordination - many frameworks and strategies but challenging to translate into practice - many agencies doing different things<br>• There is less stigma for people with mental illness or mental health issues – more acceptance in mainstream health and in workplaces, schools.<br>• Recovery oriented practice and peer workforce, trauma informed care etc = new concepts gaining traction but not understood well by all yet<br>• Convey the message that it is OK to seek other forms of help if what you are accessing isn't working for you. Don't give up. | • Knowledge and skills across the board – for all<br>• Mental health providers and public focus on competencies for providers.<br>• Better integration and cross-sector collaboration of services<br>• Moving from inflexible => flexible (services and consumers)<br>• Many ways to get help – different modalities if therapeutic interventions -> e-help apps. etc. -> especially in hard to service areas<br>• Moving from little prevention/early intervention => focus on society-wide wellbeing (not leaving acute services out though)<br>• Integration- track the money – clarity and transparency<br>• Focus on the community (co-design, co-delivery)<br>• Commitment to quality and outcomes<br>• Access and use of data and better accountability<br>• Trajectory to care, integration and coordination<br>• Looking ahead – signposts written by travelers with lived experience<br>• Evolving education requirements<br>• Looking forward – complex<br>• At present and future – more (advocacy) emphasis on consumer voice (carer perspective)<br>• The need for sufficient funding for mental health services -> future<br>• Diversity of population – CALD; Aboriginal; rural; metro; refugee; trauma<br>• Looking forward – physical health considerations<br>• Empowered commission and communities to develop innovative solutions<br>• Balance between holistic approach to mental wellbeing and targeted measures for mental ill-health<br>• Areas that need focus – forensic; disability; support of mainstream services (eg. schools; workforce capability)<br>• Accessing support – intake; needs assessment; accessing services that are responsive; equity of access (not based on $$'s); client/person focused |

## Understanding the context for the MHC: *Using the Living Well domains as a foundation*

### Process overview

Using the ten domains of Living Well as the frame for discussion, participants began this part of the forum by imagining the future landscape in which the MHC could sit. As had been agreed with the Reference Group, reflecting on the wider context would assist participants to articulate the unique and impactful role of the MHC.

Participants were asked to consider which domain they would like to contribute to, and to sit at the table that had been designated with that domain. The group was asked to self-organise to ensure that each domain had equal participants and a diversity of perspectives and experience. While the participants would have the opportunity to contribute to other domains, the bulk of their time would be spent on their chosen domain.

Each domain group was asked to answer the same two questions:

1. *What needs to happen in this domain to improve the mental health and wellbeing of the people of NSW?*
2. *How could the MHC contribute to this domain?*

The first part of the exercise involved participants reflecting on the first question. After individual reflection time, each group member shared their perspectives with their domain, and the group then created a summary of what emerged from the discussion. Participants were asked to present this in the form of a mind-map, capturing the main themes. The facilitation team felt that a mind map would be a useful way to capture the essence of how participants saw each domain improving the mental health and wellbeing of the people of NSW and would also enable others to easily contribute their thinking.

After the exercise, each domain group presented their mind-map and a summary of their discussions to the rest of the group. Participants were invited to contribute additional perspectives to each domain by adding their reflections on post-it notes.

### Synthesis across domain groups

Each domain group identified key factors that would need to happen in that domain to improve the mental health and wellbeing of the people of NSW. These ranged from the experience of consumers and carers when accessing services, to the underpinning structural and cultural drivers that would enable this. While some factors were unique to particular domains, there were common themes that emerged across multiple domains. Below is a summary of what emerged across the domains. A more detailed outline of individual domains follows this synthesis.

Participants described a person-centred mental health system that was characterised by equitable access, real choice and integrated support. Services would be tailored to consumers' needs not the system's, and access and choice would be available to all and would include hospital, community and home-based care. Consumers and carers would receive support across the lifespan, and psycho-social support to enhance all aspects of their lives and

address stigma. This would go beyond direct service delivery and into the broader community, where there would be inclusive, available neighbourhoods and communities – both online and offline.

In order for this to be realised, participants identified a range of cultural and structural factors that would need to exist:

**Authentic inclusion of people with lived experience:** This was a recurring theme and underpins many aspects of the domains. Consumers and carers would be engaged as equals in the co-design, provision, evaluation and monitoring of services. They would be in leadership roles, and there would be an increased focus on the peer workforce. This would enable services to understand the needs of consumers and carers, including people from diverse communities. Underpinning this is a culture that values diversity and inclusion.

**Inter-agency collaboration and integration:** In addition to collaboration with people with lived experience, participants highlighted the importance of different agencies working together. This could mean bringing together areas such as transport, education, housing and employment, so that multiple needs are addressed. It could also involve developing integrated responses for areas such as mental and physical health, and the intersection with the criminal justice system. Collaboration would be further supported by governance structures that gave authority to act; relevant measuring and transparent reporting; coordination of services; clarity of roles and accountability; and sufficient budget allocations and funding.

**Equity:** Participants identified a dual challenge – that there was a need to address the currently low recognition that mental illness can affect anyone, whilst also recognising that some people are more at risk than others, and that this needs to be emphasised. A dual focus on mental health literacy and equity could go some way to addressing this. Equity was seen as an important focus, as it would ensure that vulnerable groups are targeted and supported. Particular mention was made of Aboriginal people under twenty-one, people from diverse communities, and people in more remote areas where access to services is limited.

**Evidence-based practice and innovation:** Participants described an environment where there was a real commitment to best practice – both understanding and building on what works – and using this to improve and enhance services. In order to achieve this, participants discussed the need for processes and IT systems that capture and monitor key information and the collection and access to data, including important data that is currently not collected. Transparent reporting, along with an openness to change and open dialogue would enable innovation. This would require the courage to embrace and learn from failure and make hard decisions.

**Capacity building and ongoing learning:** Participants spoke about the importance of having an informed and trained workforce, including other professionals outside the mental health sector, such as GPs, and the general public. Mental health literacy and trauma-informed practice were identified as key areas of focus. Supervision and training would ensure ongoing learning and support.

**Prevention and early intervention:** The focus on prevention and early intervention would need to be across the lifespan and would be seen in both planning and service delivery.

**Reduction of stigma:** Participants identified stigma reduction as a key cultural factor to improve the mental health of the people of NSW. This could be aided by broader mental health literacy, using the language of wellbeing instead of mental health (including wellbeing of the nation) and ensuring that stigma reduction is incorporated into broader planning.

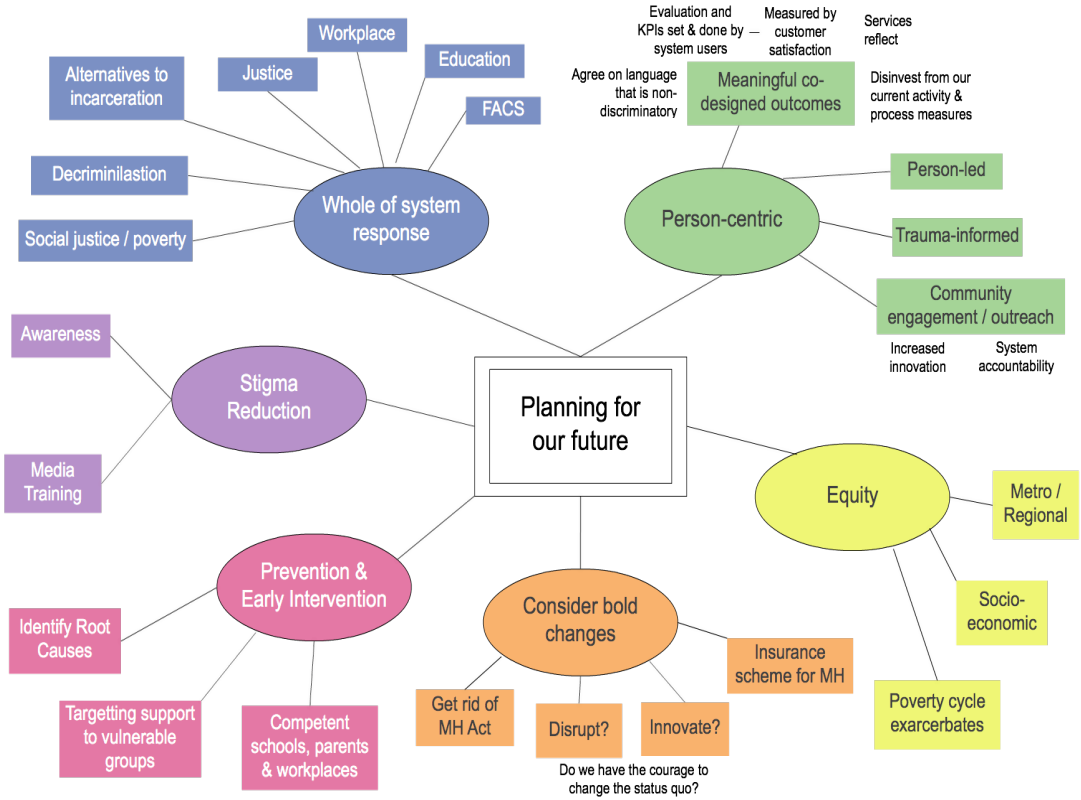
On the following pages is an overview of each separate domain, incorporating a mind-map that reflects those completed by participants, and a written summary. The summary incorporates the participants' mind-map, additional notes and verbal contributions during the shared discussion.

## 1. Planning for our future

*This domain is focused on the vision for the mental health and wellbeing of the people of NSW*.

Participants described an environment that was truly person-centric: whole of lifespan; whole person; culture; geography; economic; whole of health; whole of education. People with lived experience would be involved in all aspects of evaluations – from development of meaningful outcomes to measurement. Services would be trauma-informed and would incorporate community engagement. Importantly, person-centred would include person-led.

Equity was seen as an important focus, including targeting vulnerable groups and ensuring equal access for people in more remote areas. Particular mention was made of Aboriginal people under twenty-one. Planning would focus on prevention and early intervention, and stigma reduction. Participants suggested that some bold changes may need to be considered.



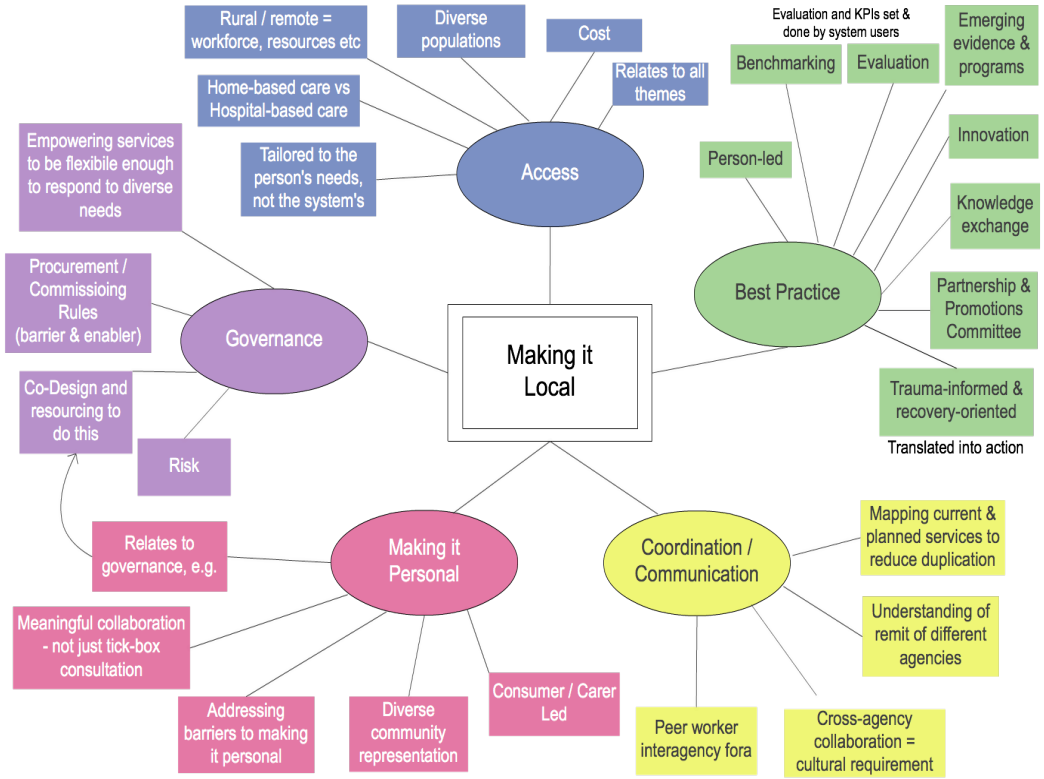
## 2. Making it local

*This domain is focused on strengthening local action through partnerships, including in diverse communities*.

Participants stressed that person-centredness underpinned all aspects of this domain. Consumers would have real access to services – tailored to their needs not the system's. This would mean choice that is not limited by factors such as geography and cost, and would include looking at hospital vs home-based care. Access was seen as a factor related to all other aspects of this domain.

People with lived experience would be engaged in real ways – as leaders and through meaningful co-design. This would include involvement in the development, implementation and measurement of KPIs and evaluation.

This domain would be underpinned by structures that: fostered collaboration and person-led practices; enabled best practice; empowered services to respond to diverse communities; reduced duplication of services.

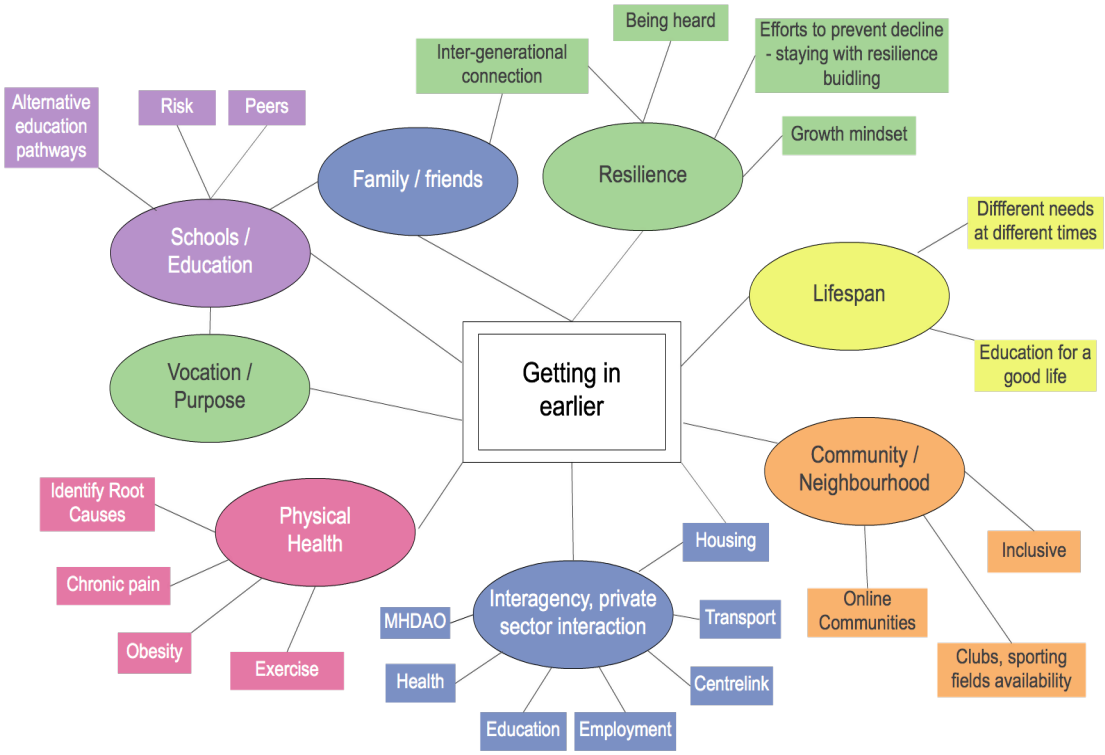


## 3. Getting in earlier

*This domain is focused on targeting social factors that foster or impede good mental health and community resilience (including understanding co-determinants and comorbidities).*

If this domain was working effectively, consumers and carers would experience support across the lifespan, recognising that there are different needs at different times. They would receive support in other aspects of their lives. There would be a focus on the development of wellness plans and resilience; vocation and purpose; and family, friends and community.

This domain would be enabled by inter-agency and private sector interaction – bringing together areas such as transport, education, housing and employment. There would be integrated approaches to mental and physical health and inclusive, available neighbourhoods and communities – both online and offline. There would be a commitment to building on what works. Participants felt that culture change is needed for this domain to be successful.

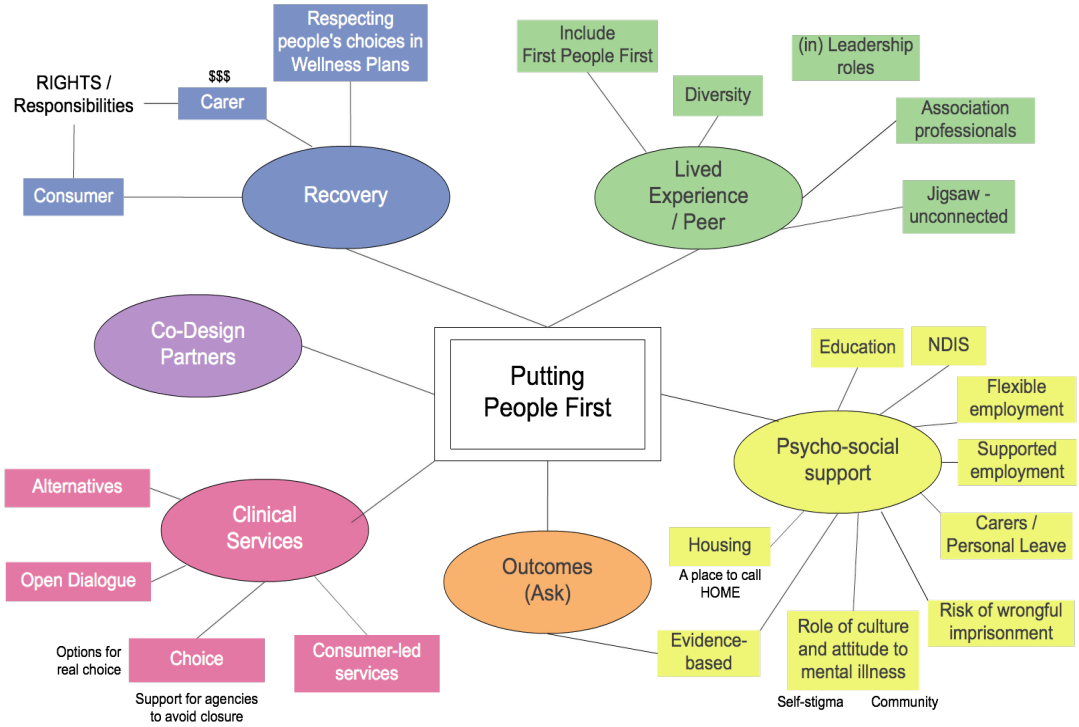


## 4. Putting people first

*This domain is focused on ensuring the needs, priorities and lived experience of those with mental illness and their families and carers are put first*.

Participants painted a picture of people with lived experience – consumers and carers – being truly at the centre and in leadership roles. This would be in all aspects of service design, delivery and evaluation. People with lived experience would have psycho-social support to enhance all aspects of their lives and address stigma. They would have real choice when it comes to clinical services. Recovery would incorporate both rights and responsibilities of consumers and carers (including financial support), and there would be respect for people's choices. Particular mention was made of putting First Peoples first.

This domain would be underpinned by structures and a culture that enabled real leadership, co-design, choice and reduction of stigma. The Peer workforce (both consumer and carer) would be in leadership roles and recognised as association professionals. Real choice would also be enabled by open dialogue, consumer-led services and agencies being supported to avoid closure of services.



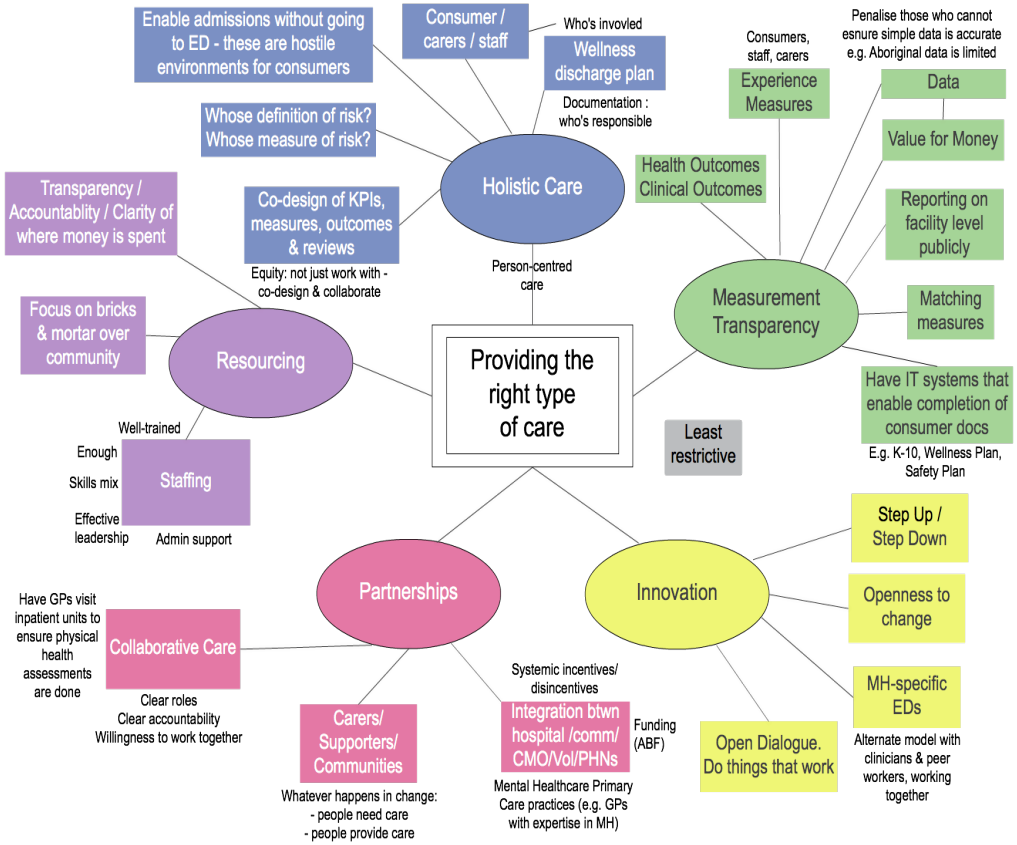
## 5. Providing the right type of care

*This domain is focused on ensuring appropriate care is available (hospital-based care and community care).*

To provide holistic, person-centred care, consumers and carers would be engaged as equals in the co-design, provision and monitoring of services. It would be true collaboration. Examples given included the development of discharge plans, and mental health specific emergency departments in which clinicians and peer workers worked together. Consumers would benefit from models of collaborative care, including GPs who have mental health expertise.

Participants identified a range of enabling structural and cultural factors. Processes and IT systems that capture and monitor key information would facilitate the collection of data - important to measuring what works. Transparent reporting, along with an openness to change and open dialogue would enable innovation.

Key to successful partnerships would be integration between institutions and stakeholder groups (including consumers), clarity of roles and accountability, and funding. There would also be proper resourcing.



## 6. Better responses

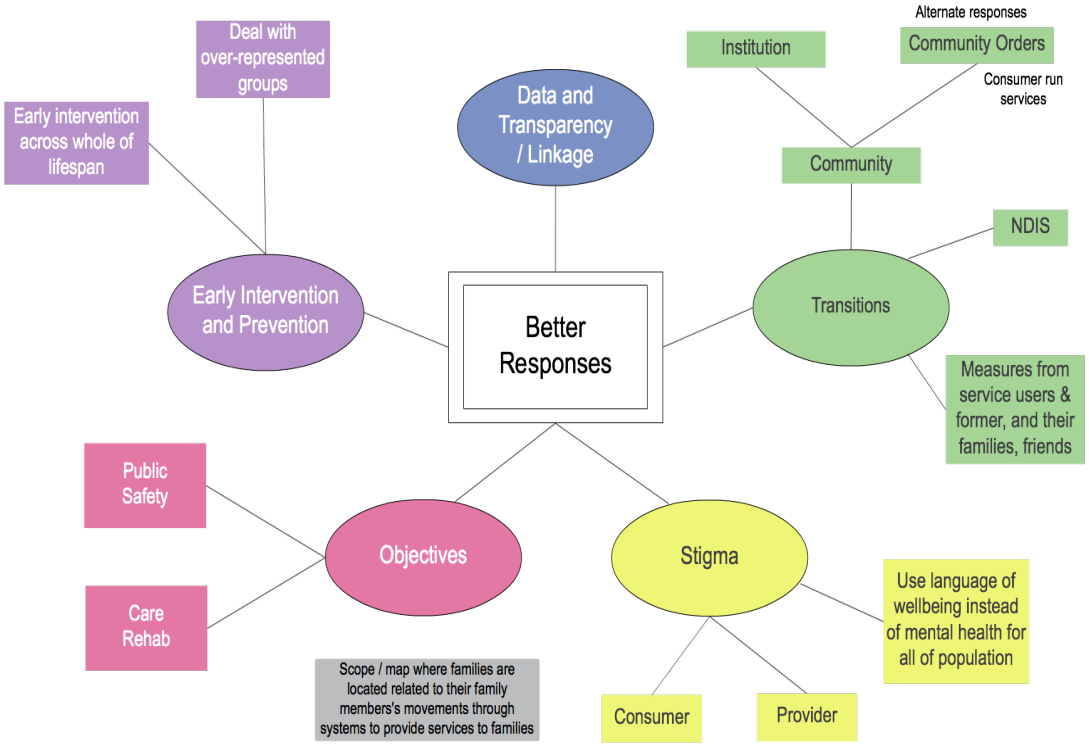
*This domain is focused on integrated care and response (including across other sectors/systems eg. justice, homelessness).*

Participants in this domain emphasised that better responses mean integrated responses. An important aspect of this would be data that could be accessed or generated to improve and monitor systems. The group highlighted the particular challenge of the intersection with the criminal justice system and implications for people within and connected to the system.

If this domain was working effectively, there would be a focus on transitions, and measures for understanding what is needed would be developed with current and former service users, and their families and friends.

Early intervention and prevention would focus on over-represented groups, and consider the whole of lifespan (early intervention is not just about age).

Stigma was recognised as a key challenge, which could be partly addressed by using the language of wellbeing instead of mental health.



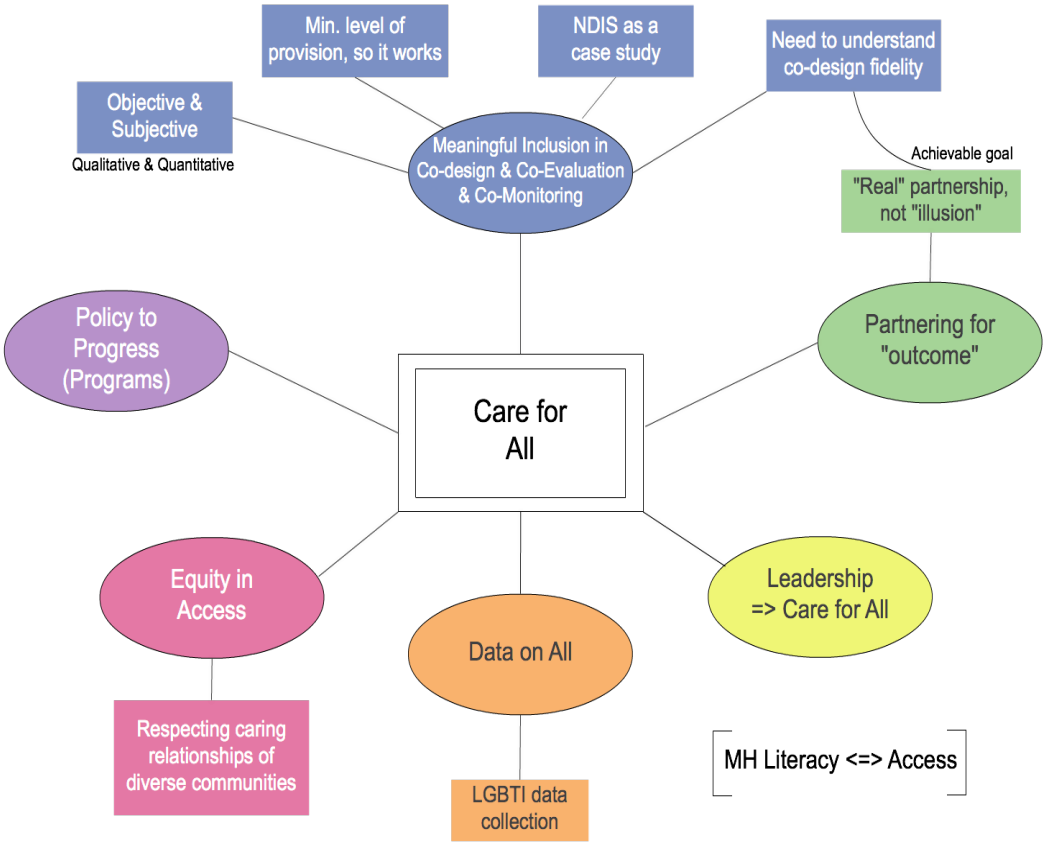
## 7. Care for all

*This domain is focussed on ensuring care is available through diverse communities (eg. multicultural, LGBTI, disability).*

A mental health system that cares for all first needs to understand the needs of consumers and carers from diverse communities, recognising that crossovers exist within groups. Furthermore, the system needs to understand the diverse range of caring relationships. Participants noted that they preferred care ***with*** all, which reflects their emphasis on meaningful inclusion of people with lived experience - through co-design, co-evaluation and co-monitoring. One way of doing this would be through meaningful, feasible and concrete collaborative projects.

Participants said that ensuring that the right care is available for diverse communities requires data that is currently not collected. One suggested way of addressing this would be for admissions to collect demographic profile data.

Participants also highlighted the importance of improved mental health literacy. This would help people navigate the system and also address the currently low recognition that mental illness can affect anyone - while also recognising that some people are more at risk than others, and that this needs to be emphasised. Particular mention was made of First Nations People.



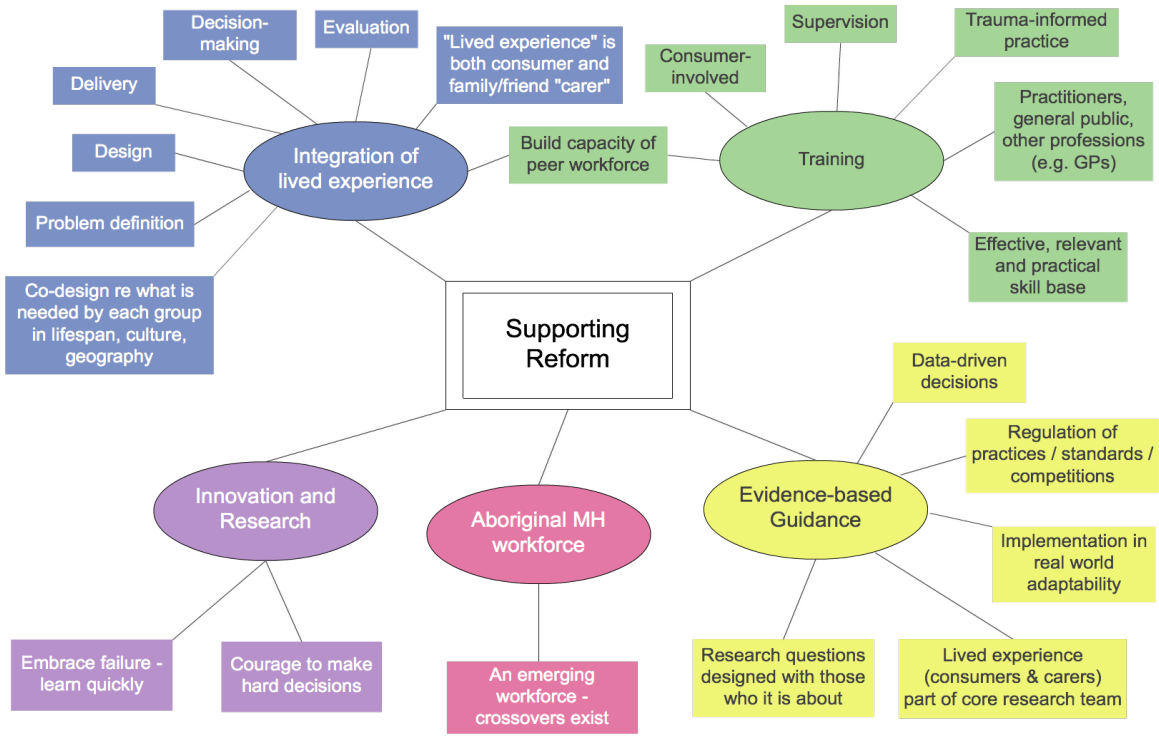
## 8. Supporting reform

*This domain is focused on supporting reform through capacity development (eg. peer workforce, technology, new capabilities, research).*

Participants in this domain highlighted the importance of supervision and training across the system, including the peer workforce, practitioners, other professions (like GPs), and the general public. Trauma-informed practice and the development of an effective, relevant and practical skill base would be crucial. It was noted that the Aboriginal mental health workforce is an emerging workforce.

In addition to the peer workforce, the broader integration of lived experience was seen as essential for reform – across lifespan, culture and geography, and in all aspects of design, delivery, decision-making, research and evaluation.

Reform would also be enabled by the provision of evidence-based guidance to enhance services, and through innovation - the courage to embrace and learn from failure and make hard decisions.



## 9. Governance of mental health within New South Wales

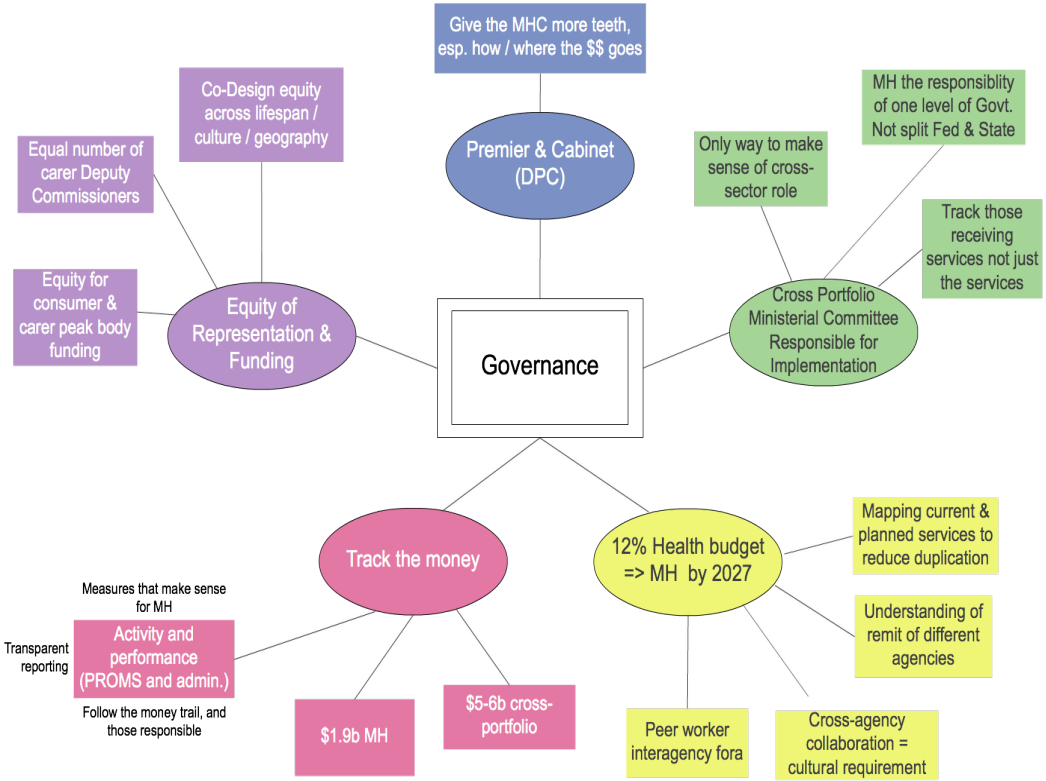
*This domain is focused on effective governance (eg. planning, funding transparency)*.

A 10-year aspiration to improve mental health outcomes and funding would be enabled by a blend of shared responsibility, equal representation, adequate funding and tracking, and authority.

A cross-portfolio Ministerial committee, including higher-level leaders who can make changes and are accountable for their role, was seen as the "only way to make sense of cross-sector role". Relevant measuring and transparent reporting would enable tracking of funding, activity and performance.

Reflecting on the MHC specifically, participants considered that it needed authority, and for this to happen, the governance should shift from Health to Department of Premier and Cabinet. Even though other options could be considered the participants felt that only the Premier could take charge of the MHC and make things happen. Carer and consumer representation was also seen as important.

Participants in this domain noted the strong consensus about what's needed. It should be further noted that this does not necessarily represent broader system consensus.



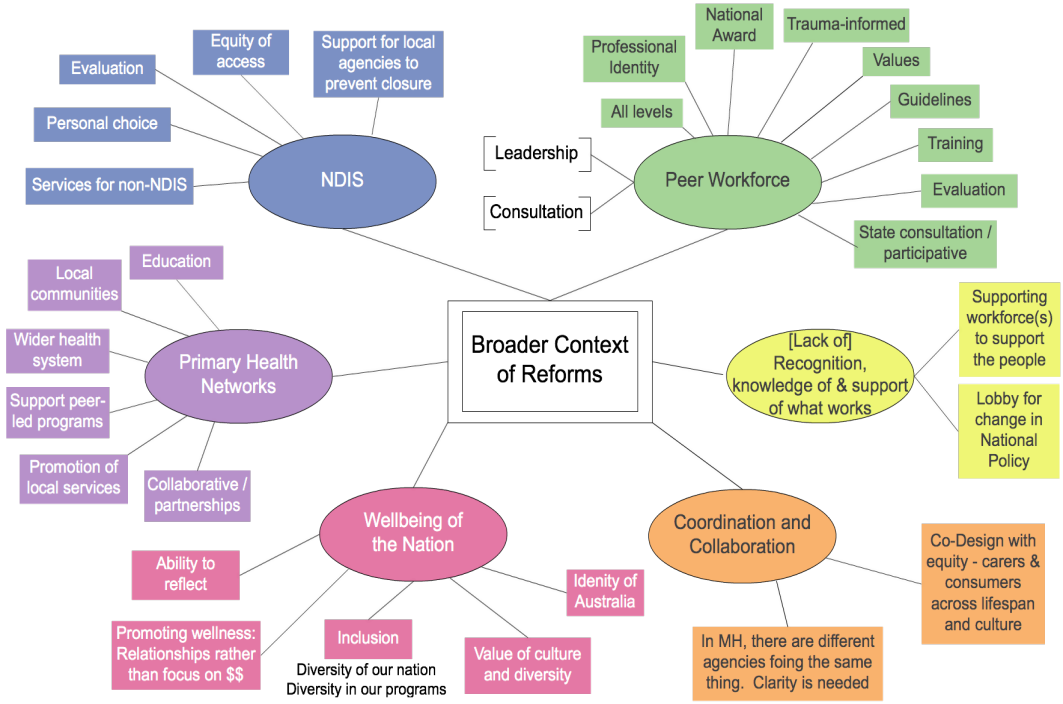
## 10. Broader Context of Reforms

*This domain is focused on ensuring mutual support and integration with broader state and national social policy development and action*.

Participants recognised the challenges of the current mental health system in NSW, with the added complexity of other reforms, including the NDIS, Primary Health Networks, state plans, national plans and funding models. Participants identified some key enablers – focusing on the perspectives of people with lived experience through leadership and consultation; coordination and collaboration to provide clarity; and focusing on the wellbeing of the nation.

People with lived experience would play a key role, with leadership and consultation of the peer workforce at all levels, and "co-design with equity" across lifespan and culture. Participants felt that "providing supportive workplaces for peer workers…will drive improvement in ALL workplaces for ALL".

Focusing on the "Wellbeing of the Nation" and the value of a culture of diversity would enable inclusion – "diversity of our nation, diversity in our programs".



## How can the MHC Contribute? *Developing the functions, involvement and focus for the MHC*

In order to determine the *unique and impactful* contribution of the MHC, participants moved through several processes of refinement. Beginning with some initial thinking in their domain groups, participants then had a more focused discussion about the potential functions of the MHC. They themed their initial thinking into key function areas – initially in domain groups and then as a whole group. Finally, participants suggested the level of involvement of the MHC in delivering outcomes against these functions if the MHC is to be unique and impactful. From this, each group selected their most important three functions.

The detailed comments/insights which gave rise to the theming into functions, the type of involvement of the MHC, and the three most important functions as identified by the participants for the MHC to perform is attached in Appendix 'B'.

### Initial thinking in domain groups

After considering the context through the domains exercise above, the participants commenced thinking about how the MHC fitted in with these contexts. Participants reflected on the potential contribution of the MHC to their domain - *looking at what would need to be happening in this domain if the MHC can add value, and if so, how? What are the gaps and needs?* Each participant captured and noted their thoughts for use in later discussions.

It was emphasised to the group that this activity was an initial 'brain dump', and that next they would review and refine these to find the unique and most impactful role, functions and priorities.

### Identifying functions, involvement and focus

At their domain tables, participants clustered their collective insights into themes. These themes were then shared with all participants to see the common insights from the wider group might suggest the future and desired functions for the MHC.

The following possible function areas emerged from the theming exercise that involved all participants:

- Systems engagement and collaboration
- Community engagement
- Strategy
- Planning and monitoring
- Consumer/Carer outcomes
- Data collection and dissemination
- Promote innovation

- Independent voice
- Advocacy

After identifying the desired function areas, the group considered how the MHC might contribute in a unique and impactful way, and the extent of its involvement. This recognised that the MHC isn't able to do everything, it is unable to fix the entire system on its own. Using a process called the Involvement Model, participants considered five possible levels of involvement for the MHC. Looking at each of the possible function areas, participants considered whether the MHC would:

1. Be **accountable** and **responsible** for an outcome
2. Have **shared responsibility** for outcome delivery through **collaboration**
3. **Not be responsible** for outcome delivery but can **add value** through **co-operating** with others
4. Have **no** obvious **responsibility** or contribution to make in delivering outcomes
5. Have **other** type of involvement (specify and describe)

Finally, in order to get as focused as possible on the desired future functions of the MHC, each participant was invited to vote for their top three function areas that they would like to the MHC to focus on. A voting process was used for the participants to identify the top three functions. To guide their thinking, they were asked to answer the following question:

*If the MHC could only perform three functions, which ones should they be?"*

The results of the voting exercise suggested that the MHC should focus on the following three function areas:

- Consumer/Carer outcomes
- Independent voice
- System engagement and collaboration

The facilitation team observed that these three function areas are consistent with the key messages that were emphasised throughout the forum and in the interviews with the Reference Group. The three key messages are:

- The consumer/carer voice is needed to guide and be embedded in the forming and operating of the system;
- An independent voice is needed to transcend departmental/agency perspectives and have a legitimacy in the system;
- System engagement and collaboration is necessary for all of the parts to come together and to achieve integrated outcomes.

The consistency of these key messages suggest that the participants feel these three functions are either not currently present, or not present to the extent necessary to achieve better mental health and wellbeing outcomes for the people of NSW.

The following table is in order of those functions which attracted the most votes. Note that the Desired Function column is a verbatim use of the words of the participants to stay true to their contribution. However, the Suggested Contribution column is a synthesis of the data collected (see Appendix 'B'); and the Extent of Involvement is an analysis of the participants response to the Involvement Model mentioned previously.

The desired functions emerged from the participant discussion. As to why they emerged, this can be viewed from the perspective of what they see as function — presently missing in the system or maybe present but not obvious to them, thereby requiring enhancement or emphasis. Furthermore, the participants were not asserting that the MHC is 'totally responsible' for the change or reform of the system. However, in the eyes of many of the participants, it would be for the better if these desired functions—as critical parts of the system—are focused upon change could occur.

| Desired Function | Suggested Contribution | Extent of Involvement |
|---|---|---|
| Consumer/Carer Outcomes (44 votes) | The participants, many times throughout the forum, spoke of the need for the system to be cognizant of the voices of those with lived experience and how this should guide the design of the system and services to achieve consumer/carer outcomes. This includes having peer champions bringing the consumer/carer voices into the system, and that those with lived experience actually hold leadership positions, thereby informing specific partnerships in all levels of service design and delivery.<br><br>It should be noted that even though the participants refer to outcomes in this Desired Function (see first column) this would need to be considered in the context of the larger system. It would be difficult to hold the MHC totally responsible for this to occur but as can be seen from the next column, 'Extent of Involvement', the participants recognized the MHC could have a shared responsibility for the outcome delivery through collaboration. Again, this points to both the structural and capability factors which would allow the MHC to do this effectively.<br><br>**Uniqueness** is through the MHC providing the consumer voice into the system and ensuring fidelity in consumer engagement. It could have a whole of system presence in facilitating the consumer voice being heard.<br><br>**Impactful** through providing a leadership role that shines the light into co-design and reform processes, built through the voice of lived experience. | The extent of MHC involvement for this function was seen as the MHC:<br>*"Having **shared responsibility** for outcome delivery through **collaboration**"*<br>(To a lesser extent it was seen by the participants that the MHC:<br>*"Be **accountable** and **responsible** for an outcome.")* However, as mentioned in the previous column, given the complexity of the system, it would be difficult for the MHC to have sole accountability and responsibility for the overall outcome, but possibly could be accountable and responsible for contributing through influence and collaboration. |

| Desired Function | Suggested Contribution | Extent of Involvement |
|---|---|---|
| Independent Voice (21 votes) | The desire for an independent voice within the mental health system was seen as important, and the MHC could fulfil this role. There were different perspectives as to such independence, for example the MHC should report directly to the Premier (through DPC) or, also as suggested, to Parliament. Even though these options are perspectives of the participants the key desire is for an independent voice that could express views as to the effective operation of the system. The perception is that at the moment different interests and competing priorities of departments/agencies could hinder the understanding of the effectiveness of the system and an independent voice answerable to an overarching authority could transcend different interests.<br><br>There may be other structural, legislative and process options to be explored which could achieve such independence. Suggestions from the participants included regular transparent expenditure reporting of the State's mental health budget.<br><br>It was also suggested the Commissioner and Deputy Commissioners should be individuals with lived experience. This perspective/suggestion again indicates the depth of desire from many of the participants in embedding the voice of lived in many elements of the system.<br><br>**Unique** through its independence and being able to provide strong, fearless and strategic overview of the mental health system.<br><br>**Impactful** in that with this independence and in having a high profile in the community the MHC could speak freely and frankly with credibility. | The extent of MHC involvement for this function was overwhelmingly seen as:<br><br>*"Being **accountable** and **responsible** for an outcome"*<br><br>The MHC has a primary and significant contribution to be an independent voice and indeed should be accountable to ensuring this voice is clearly heard in the mental health system. However, enabling legislative, procedural and structural changes may need to be in place for the MHC to undertake this function and be accountable. |

| Desired Function | Suggested Contribution | Extent of Involvement |
|---|---|---|
| System engagement and collaboration (18 votes) | This desired function for the MHC recognises that mental health is actually influenced by, or influences, other social issues which are managed or addressed through other systems/sectors. These include comorbidities such as drug and alcohol addiction, or issues that influence or are influenced by mental health, such as housing, education and employment and even the influence of the justice system including corrections. With such complexity, how can engagement and collaboration occur across other complex systems/sectors with that of mental health to effect holistic response? The MHC could contribute to having the mental health system connect to the other actors/systems to achieve strategic objectives.<br><br>**Unique** in that it can have a direct and independent line to government. It can take a system perspective rather than just service.Also, can have strong leadership in the sector.<br><br>**Impactful** in that it can convey the voice of the community and consumer. Span across sectors and be an important contributor to reform. | The extent of involvement for this function for the MHC was seen overwhelmingly as:<br>*"Have **shared responsibility** for outcome delivery through **collaboration"***<br>(to a lesser extent:<br>*"Be **accountable** and **responsible** for an outcome"*<br>But this was only if MHC sat within Department of Premier and Cabinet.<br>Also, once mentioned was the MHC:<br>***"Not be responsible** for outcome delivery but can **add value** through **co-operating** with others")* |

| Desired Function | Suggested Contribution | Extent of Involvement |
|---|---|---|
| Advocacy (15 votes) | There was significant comment about the contribution the MHC can make to advocacy. Even though this could also be related to the independent voice, it also included advocating departments/agencies working together for those needing mental health services (eg. justice, housing, education and communities); highlighting deficiencies in the system; challenging stigma; trauma informed care; acknowledging the past to move forward. It was foreseen that the MHC could advocate for the voices of those with lived experience into policy development both within NSW but also the national platform such as NDIS.<br><br>**Unique** in that the MHC could provide an independent view led by those with lived experience; has access to decision makers and also have a strategic perspective.<br><br>**Impactful** in that it can with credibility speak freely and frankly regarding complaints on issues at a system level and can be a cross-sector advocate. | The perspective of the participants was that the MHC had significant involvement for this function but was evenly split between:<br><br>*"Being **accountable** and **responsible** for an outcome"*<br>and<br>*"Having **shared responsibility** for outcome delivery through **collaboration"***<br>Further work with stakeholders is needed to clarify the distinct role and responsibility for the MHC but they clearly were seen as being significant contributors to this function with the system. |

| Desired Function | Suggested Contribution | Extent of Involvement |
|---|---|---|
| Data collection and dissemination (14 votes) | This desired function was again seen to be at the strategic level for MHC. It considered that ensuring consistency and standardisation in data collection and dissemination through integrated data sets will enhance evidence based and data driven decision making. This in turn will assist research that can measure improvement in the system and drive best practice. Good data collection, analysis and dissemination will facilitate transparency and hence accountability. This issue of transparency integrates again with the element of an independent voice. This would allow evidence based and credible advice to government together with independent evaluation and monitoring of services. It also included a contribution to a clearing house function again supporting understanding of best practice.<br><br>**Uniqueness** through having a whole of system perspective.<br><br>**Impactful** through being able to promote excellence in practice and also having an independent power to collect data that could contribute to accountability. | Overwhelmingly the participants thought the MHC had significant involvement:<br><br>*"Having **shared responsibility** for outcome delivery through **collaboration**"*<br><br>Overall there is a contribution for the MHC in providing strategic, systemic value and using data for transparency and in informing best practice.<br><br>(There was one perspective that also considered, the MHC is:<br><br>*"**Not responsible** for outcome delivery but can **add value** through **co-operating** with others")* |

| Desired Function | Suggested Contribution | Extent of Involvement |
|---|---|---|
| Community engagement (12 votes) | There were some perspectives as to the value of the MHC undertaking community engagement. One is having strong and close connections to both community leaders and specific partnerships to facilitate and understand the achieving of mental health outcomes. Another is through an advocacy role whereby the MHC understands the issues at community level so as to ensure the right voices are being heard. This perspective of contributing through advocacy appeared to emerge from participants feeling that the MHC, as a known institution, will more likely be listened be listened to by key stakeholders.<br><br>**Unique** in that the MHC can provide a systems lens, not services. It can have a perception of trust in the community.<br><br>**Impactful** in that it can build credibility, be known and heard. It can apply consistent principle with meaningful engagement. It also has the ability to provide broad engagement across the State (that is it has a statewide focus). | In considering the involvement of the MHC in this desired function participants were fairly evenly spread between:<br><br>*"Being **accountable** and **responsible** for an outcome"*<br><br>and<br><br>*"Having **shared responsibility** for outcome delivery through **collaboration"***<br><br>(There were a couple of perspectives also that considered the MHC be:<br><br>*"**Not responsible** for outcome delivery but can **add value** through **co-operating** with others**")*** |

| Desired Function | Suggested Contribution | Extent of Involvement |
|---|---|---|
| Strategy (10 votes) | A need for a vision and strategic plan for the mental health system was seen as critical and a contribution the MHC could make. Again, to be at system level or 'big picture'. It would move from a reactive approach to one that is proactive. It was also seen as setting priorities and monitoring government agency performance against such priorities and enabling services to work together.<br><br>**Unique** in that the MHC could take a whole of government perspective and be an overarching view beyond health. The MHC has the potential to take a strong leadership role across sectors particularly in merging service strategies.<br><br>**Impactful** through having ownership of a system strategy and could even support 'disruptive' strategies. Capacity to take longer term view and move beyond 'delivery' remit. | In considering the involvement of the MHC in this desired function participants believed largely that the MHC:<br><br>*"Being **accountable** and **responsible** for an outcome"*<br><br>(A couple of participants thought the MHC should be:<br><br>*"Having **shared responsibility** for outcome delivery through **collaboration**"*<br><br>or<br><br>*"**Not responsible** for outcome delivery but can **add value** through **co-operating** with others**")*** |

| Desired Function | Suggested Contribution | Extent of Involvement |
|---|---|---|
| Promote innovation (9 votes) | In this desired function the participants spoke of both best practice and innovation. From the perspective of best practice, the MHC is seen as contributing through seeking and identifying in the system best practice and then sharing this. This fits with the clearing house contribution in Data Collection and Dissemination but again at the strategic level and in seeking strategic objectives. From the perspective of innovation, the MHC could also commission and fund innovation, research and evaluation. The MHC was also seen as a body that could facilitate the reduction of systemic barriers in order to create opportunities for local innovation and activity.<br><br>**Unique** in that it can take a lead role in showcasing innovation and facilitating the sharing of best practice, particularly with an overarching view of the system.<br><br>**Impactful** in that the MHC can have credibility within the sector and can, in being independent focus on consumer/carer views in both best practice and innovation. | The MHC extent of involvement in this instance was in collaboration and cooperation with others. It was largely regarded as:<br><br>*"Having **shared responsibility** for outcome delivery through **collaboration**"*<br><br>and<br><br>*"**Not responsible** for outcome delivery but can **add value** through **co-operating** with others"* |

| Desired Function | Suggested Contribution | Extent of Involvement |
|---|---|---|
| Planning and monitoring (2 votes) | The MHC could contribute to planning through service system mapping which could match funding to need. This includes defining and sharing best practice standards in priority area eg. Trauma informed care.<br><br>**Unique** in that it can have system level engagement and bringing the voice of lived experience into planning processes.<br><br>**Impactful** in that they would be trusted and independent. | The extent of involvement would be:<br><br>*"Having **shared responsibility** for outcome delivery through **collaboration**"*<br><br>(To a lesser degree:<br><br>*"Being **accountable** and **responsible** for an outcome")* |

### High-level observation as to the functions

In looking at the functions and the underpinning comments or insights, there are a number of perspectives or observations that reflect the fundamental concerns of the participants. One insight concerns the MHC having shared responsibility, or the need for collaboration in delivering outcomes. A framework - possibly even one that is legislated - to assist in legitimacy and accountability for collaboration will be required. Even though there are many ways this legitimacy and accountability could be built, some of the participants recommended the MHC should be moved into the Department of Premier and Cabinet to ensure accountability across government departments/agencies. Even though such formal mechanisms could be considered, it would be wrong to solely rely on these to generate effective collaboration.Another option to consider would be to further develop capabilities within the MHC that create generative and effective co-design and collaboration through changed behaviours across departments/agencies, both government and non-government.

A further observation is that there is an overlap between some of the desired functions and even an interdependency. For example, there is system engagement and collaboration, and also community engagement, which could overlap. To remain faithful to the outcomes of the discussion over the day, we didn't conflate the desired functions as identified by the participants. An example of interdependency is that for the MHC to be an independent voice, is it will need access to accurate data and analysis. Further work and definition or clarity of each of the desired functions may identify the overlaps and see where some of these functions can be grouped even further.

When looking across all of this work, it was clear that in any function the MHC takes up it should be at the strategic and system level. This could highlight what many participants feel is presently missing – an entity that is keeping an eye on system outcomes **and** through the eyes of lived experience, as opposed to disconnected department/agency outputs.

Another strongly expressed view is the ability for the MHC to have a profile in the mental health and related systems, which is credible, independent and trusted. If the MHC can be seen by government, non-government agencies, policy makers and the community in this light, they would provide a unique and impactful contribution to the health and wellbeing of the people of NSW. One key theme across all the desired functions is that the MHC has a strategic role – not to get too low into the delivery of service, but a more high-level contribution that can achieve systemic outcomes and directly relatable to those with lived experience, including carers.

### What could be the role of the MHC?

The next step was to identify a role for the MHC. The present structure of the MHC role as defined in the Mental Health Commission Act, is:

***"The Commission was established for the purpose of monitoring, reviewing and improving the mental health system and the mental health and well-being of the people of NSW"***

Using the present structure above and reflecting on what had been discussed over the day, the group was asked to craft a role statement.

The proposals received during the forum as to the future role of the MHC (bold indicates key words):

1. The Commission is established for the purpose of improving mental health **reform** and the health and well-being of the people of NSW by **ensuring accountability** of mental health systems.
2. The Commission's purpose is to **advocate** with and **support a community-driven, evidence based** mental health system.
3. The Commission exists to **promote** the mental health and well-being of the people of NSW by **reviewing the effectiveness** of the mental health system, **fostering innovation and providing a safe and empowering forum** for people with **lived experience**.
4. **Identify** the government **responsibilities** to **ensure** community emotional safety and **funds** required to facilitate accountabilities.
5. The Commission is established to **ensure the voice of lived experience** and carers drives the reform of the mental health system, and to monitor and review the mental health and well-being outcomes of the people of NSW.
6. The Commission was established for the purpose of **supporting** and **improving** the mental health and well-being of the people of NSW.
7. The Commission was established for the purpose of **monitoring**, **reviewing** and **improving** the mental health system and the mental health and well-being of the people of NSW, **with and for, consumers, family and carers**.
8. The Mental Health Commission **supports** the **voice of consumers and carers** across the **mental health and other government systems**, **representing** their needs to **enable positive reform** to **improve the lived experience** of consumers of objective health and social outcomes they are supported to achieve.
9. The Commission is established for the purpose of **monitoring, reviewing** and improving the services for **people with a mental illness** and their **carers** and to improve the well-being of the people of NSW.

In looking at the role statements developed by the group, it was noticed that:

- There is a more explicit role proposed for the MHC in advocating for bringing the voice/needs of consumers, carers and their families (those with different forms of lived experience) into the reforms of mental health and other government systems.
- The use of verb "support" to describe relationship with those with lived experience – as an ally and advocate within the system.
- The call for reviewing effectiveness of services in a community-driven and evidence-based approach.
- A couple of proposals focus on accountability/ensuring/responsibilities but majority use verbs like support/foster/promote/empower.

Whilst the proposed role statements from the participants capture much of what was discussed during the day, the following attempts to craft a role statement that embraces the intent of what emerged in the discussion.

***The Commission exists to provide - through the voice of lived experience - independent, systemic and strategic direction for the mental health and wellbeing of the people of NSW.***

Use of the words 'promote'; 'reviewing the effectiveness'; 'fostering innovation, 'best practice'; safe and empowering'; 'lived experience'; and 'carers' addresses the functions previously identified. The facilitators understand that even though this statement assists in defining the role of the MHC, how the role can be undertaken would need to be explored further, as this role could be realised in many different ways. However, the role statement, at a high level, reflects the intent and desire of the group at the Forum.

## What could be the priorities of the MHC?

While there was not sufficient time to undertake a thorough process to identify the strategic priorities, to understand an early sense of possible priorities of the MHC, participants were asked to consider the following question:

*"Given all of our discussions today, what should the MHC focus on in the next three years to have the biggest impact on promoting the well-being and mental health of the people of NSW?"*

The responses from six tables were:

**A**

1. Revisit the strategic plan and make it relevant
2. Conduct a financial flow analysis across all relevant departments
3. Become a champion for consumers and carers with lived experience

**B**

1. Capture and advocate for consumer and carer voice

2. 14% of health funding to mental health.
3. Commitment to basic level of service planning by region across health funders (LHD/PHN etc) and across continuum of care.
4. Use experiences of service and other data to externally evaluate

**C**

1. To facilitate and empower the voice of people with lived experience and carers and families.
2. Review and report trauma-informed and recovery focus practices across the mental health systems
3. Establish a clearing house of efficient and effective practices that are trauma-informed, recovery-focused and consumer-led

**D**

1. Plan and hold a range of opportunities, both face to face and in a way that introverts can contribute, to inform MHC on what they need to be supported and to have their lives improved. Not a one-off and not prescribed. Letting the people talk and be heard.
2. Reposition the Commission to sit in the Premier's Department, but ensure all other agencies are informed of MHC role and functions so there is no duplication.
3. Solve significant issues with access (affordability etc) – ensuring solutions are sustainable.

**E**

1. Include lived experience and carers and get clear on what outcomes we want to achieve.
2. Based on outcomes, decide what data should be collected.
3. This will show whether the services are meeting the needs – big picture community well-being.

**F**

1. Access to immediate and appropriate care, including access to alternatives including hospital care, early intervention and step up and step down care.
2. Intentional inclusion of lived experience as found in the lives of consumers, carers and family in a peer capacity, as a workforce.
3. Equity and equality in accessing mental health services.

In considering what emerged from the tables the following themes became obvious:

| General priority description | Details | Number of inclusions |
|---|---|---|
| Lived experience of consumers, carers & family | • Champion<br>• Capture<br>• Advocate<br>• Intentional inclusion<br>• Peer workforce | All groups |
| Access to mental health care | • Affordable<br>• Equity<br>• Equality<br>• Alternatives<br>• Appropriate<br>• Early intervention<br>• Basic level of service across all regions and continuum of care | Four inclusions |
| Review and evaluate services | • Trauma-informed<br>• Recovery-focused<br>• Consumer-led<br>• Collect the right data based on outcomes | Four inclusions |
| Planning and governance | • Strategic plan relevant<br>• Service planning<br>• Reposition MHC in DPC<br>• Avoid duplication/gaps across government agencies | Three inclusions |
| Funding | • 14% of health care budget<br>• Analysis across departments | Two inclusions |

| | | |
|---|---|---|
| Best case practice sharing | • Efficient and effective practices that are trauma-informed, recovery-focused and consumer-led | One inclusion |

The top priorities provided by participants align with the intent and emotion of the discussion throughout the forum. In trying to clarify the feedback it would suggest that the top three priorities desired of the MHC are:

- To champion and advocate across the system the voices of those with lived experience that includes intentional inclusion and building a peer workforce.
- Ensure affordable, equal and equitable (sic) access to mental health care.
- Ensure services are reviewed and evaluated and are consumer-led, recovery-focused and outcome-focused.

The framework on page 45 includes all the priorities identified in the order of importance as identified by the participants.

It is worth again reflecting on the top three function areas the group chose:

- Consumer/Carer outcomes
- Independent voice
- System engagement and collaboration

There is a consistency of what is being voiced – the right voices being heard; a system (not just confined to those delivering mental health services) that is integrated, and outcomes focused; and, the MHC is both structurally and culturally supported to be an independent voice that can drive effective response for the mental health and wellbeing of the people of NSW.

That is not to say the other named priorities are not critical, but one manner of looking at those other priorities is that they can support or facilitate the first three.

## Listening to the Voices of Lived Experience

Throughout the forum, the need to listen to the voice of those with lived experience - both consumers and carers - was frequently mentioned. However, the extent of listening to these voices was called into question, both at the forum and in the wider system experience. There was a perception that currently greater and sincere emphasis is needed to listen and respond to these voices, and that the MHC has the potential to be a significant and trusted influence in ensuring this occurs. During the forum, the underlying and fundamental problem of not listening appeared to be playing out at some tables, for it to be raised with the facilitators as a problem. The sense of frustration raised by some of the participants – those with lived experience – was the feeling that the perceived flaws in the macrocosm (the system) was being played out in the microcosm (the forum).

*For me personally, it (being heard) hasn't happened for me here today [being heard]* (Consumer)

The facilitators were approached by a participant with lived experience expressing a concern that the forum table discussions were unsafe for consumers and carers. The facilitators were of the impression this participant represented some others with a similar perspective. In particular the facilitators were informed that many of those with lived experience felt they were not being heard, whether intentionally or not, and they were being excluded from voicing their perspectives.

The facilitators paused proceedings to listen to consumers and carers and provide a moment for them to express what they wanted the rest of the group to hear and take away. A participant had commenced to respond to what was being said in regard to the efforts made in the mental health system to engage with consumers and carers, however, the facilitators consciously asked for no responses to be made and for those present to just listen and not defend nor make judgement, but to just listen.

Importantly the comments expressed the feeling, emotion and frustration felt by some consumers and carers which are presently being played out in the larger mental health system and were being reflected in the forum. The comment here by an MHC Deputy Commissioner articulated how they perceive the issue.

*What has been said has been said year after year. People don't listen. That is the issue. If people here have not felt heard until this point, then what's it like out there? We want the opportunity to live contributing lives in the community. The narrative is there – all services say we focus on consumers and carers. What we mean is true involvement, true listening, true leadership, even in strange ways, to listen to what we are saying. Services can't be there for services' sake, but for peoples' sake.* (Deputy Commissioner, consumer)

Participants with lived experience also expressed their hope that the MHC could play a valuable role in ensuring that the right voices were being heard in the right way.

*Is it the peoples' Commission that we are looking at or the Ministry's. The idea of paid participation is to allow them to develop the voice they have.* (CAC, consumer, peer worker)

*Let the MHC use these words to inform their work and speak for those with lived experience.* (Carer)

*The Commission does have to look at what we are here for. If all of these great services are available but not accessible to the needs of the consumer, then we need to fit the system to the consumer.* (CAC, consumer and peer worker)

*Simply including 'trauma-informed care' and 'recovery' in the MHC vision would be important measures over the next five years.* (Consumer)

At the end of the open space a person with lived experience stated the following:

*It's crucial to listen to the voice of lived experience. Thank you for listening, I feel heard.* (Female consumer)

The Mental Health Commissioner asked and was given space to respond to what she had just heard, paraphrased:

*Acknowledgement of the conversation, as this is what the MHC is about and why it got established. We have been growing and learning. We have to improve how we engage and more understanding of recovery and embed that in our work, as well as trauma-informed care. The values and principles remain unchanged in the Commission. One in five of us will have a lived experience at some point in our lives. We thank you for acknowledging your lived experience in front of your peers, as it's a hard thing to do, to step up and acknowledge you have a lived experience.*

From the perspective of consumers and carers, which also emerged throughout the forum, the MHC has a critical role in ensuring the voices of these people is not just heard but guides, intertwines and embeds into the system how it fundamentally operates. As stated as *true involvement, true listening, true leadership* – including those with lived experience filling leadership positions.

This part of the Forum finished with a reference back to the start of the day, when there was a discussion about the "four ways of talking and listening", and how to create a safe space in which everyone felt heard. Participants were encouraged to take home their copies of the framework so that they could utilise it in their interactions in the wider system.

## Completing the day: checking-out

The forum finished with all the participants convening in a circle with the facilitators and review team. The day had been long and intense, and a "check-out" is a way to see what shifts, if any, people may be walking away with. It is a way to close the process. They were asked two questions:

- *What are you taking away today?*
- *What are you leaving behind today?*

The comments provided by some of those present were:

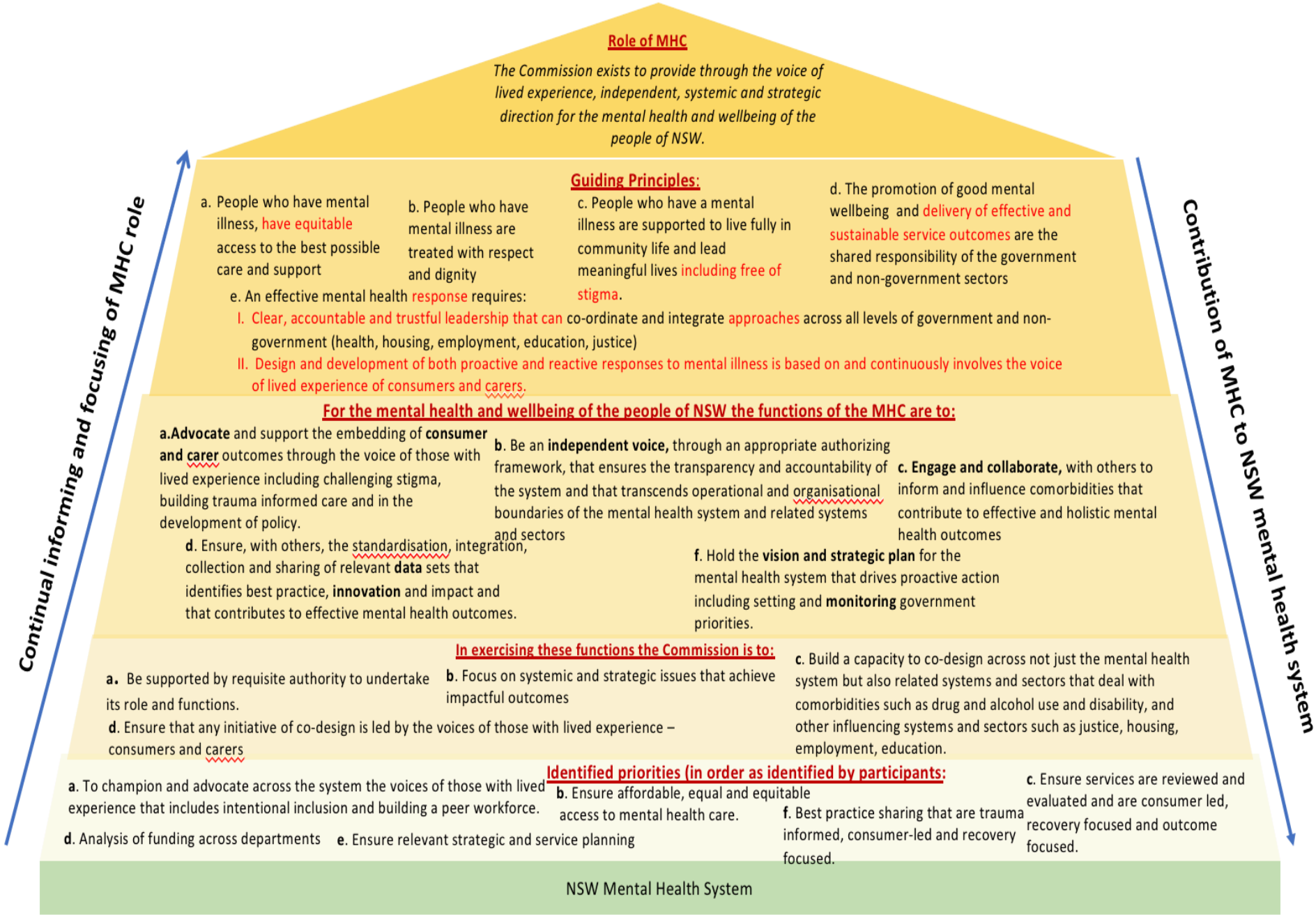
- I am taking away hope..
- I am leaving behind my voice
- I am leaving behind my embarrassment in not talking about carers today. I felt very emotional. My husband is getting worse today. Carers need to be supported. Consumers are traumatised, but those who love them are also traumatised. What about people who don't have language skills, speak another language, don't have my education, don't work in my service? It's pretty bad out there.
- I am taking away optimism for the next ten more years.
- I am taking away responsibility. There are many things we must do and that is not just the Commission.
- I am going to leave behind what we've talked about, so I can go home and tune into those who I care about. Honouring all of the conversations we've had today.
- Taking away the sense of feeling heard but wondering what will happen to all it.
- Taking away people talking about feeling not heard and marginalised and thank you for stopping to enable our voices heard – it was a beautiful thing/gesture.

## Conceptual Framework

As part of the requested forum outcomes a conceptual framework has been developed to capture the role, functions, priorities and principles to inform the future work and positioning of the Mental Health Commission. The framework relies on an analysis and synthesis of the insights and contributions that emerged from the forum.

The following framework has some **bolded** words, which emphasise some of the language used in providing the insights - in other words to show a direct line of sight to what emerged. In the Role Statement, we have included a reference to the voice of lived experience. This was done to recognise what can be regarded as the most *unique and impactful* contribution the MHC can make.

Finally, due to the shortage of time in the forum the principles were not fully covered. This was foreseen as a possibility and, in discussing this with the review team, it was decided that the functions, role and priorities were the key outcomes to deliver. But the present principles have been looked at and, even though still considered relevant, some suggested changes and additions are provided, which make them more aligned to the contributions from the forum. These are in red in the conceptual framework provided below.


Role of MHC
The Commission exists to provide through the voice of lived experience, independent, systemic and strategic direction for the mental health and wellbeing of the people of NSW.
Guiding Principles:
a. People who have mental illness, have equitable access to the best possible care and support
b. People who have mental illness are treated with respect and dignity
c. People who have a mental illness are supported to live fully in community life and lead meaningful lives including free of stigma.
d. The promotion of good mental wellbeing and delivery of effective and sustainable service outcomes are the shared responsibility of the government and non-government sectors
e. An effective mental health response requires:
I. Clear, accountable and trustful leadership that can co-ordinate and integrate approaches across all levels of government and non-government (health, housing, employment, education, justice)
II. Design and development of both proactive and reactive responses to mental illness is based on and continuously involves the voice of lived experience of consumers and carers.
For the mental health and wellbeing of the people of NSW the functions of the MHC are to:
a.Advocate and support the embedding of consumer and carer outcomes through the voice of those with lived experience including challenging stigma, building trauma informed care and in the development of policy.
b. Be an independent voice, through an appropriate authorizing framework, that ensures the transparency and accountability of the system and that transcends operational and organisational boundaries of the mental health system and related systems and sectors
c. Engage and collaborate, with others to inform and influence comorbidities that contribute to effective and holistic mental health outcomes
d. Ensure, with others, the standardisation, integration, collection and sharing of relevant data sets that identifies best practice, innovation and impact and that contributes to effective mental health outcomes.
f. Hold the vision and strategic plan for the mental health system that drives proactive action including setting and monitoring government priorities.
In exercising these functions the Commission is to:
a. Be supported by requisite authority to undertake its role and functions.
b. Focus on systemic and strategic issues that achieve impactful outcomes
c. Build a capacity to co-design across not just the mental health system but also related systems and sectors that deal with comorbidities such as drug and alcohol use and disability, and other influencing systems and sectors such as justice, housing, employment, education.
d. Ensure that any initiative of co-design is led by the voices of those with lived experience – consumers and carers
Identified priorities (in order as identified by participants:
a. To champion and advocate across the system the voices of those with lived experience that includes intentional inclusion and building a peer workforce.
b. Ensure affordable, equal and equitable access to mental health care.
c. Ensure services are reviewed and evaluated and are consumer led, recovery focused and outcome focused.
d. Analysis of funding across departments
e. Ensure relevant strategic and service planning
f. Best practice sharing that are trauma informed, consumer-led and recovery focused.
NSW Mental Health System
Continual informing and focusing of MHC role
Contribution of MHC to NSW mental health system

## Conclusion

The forum was designed to deliver the desired outcomes requested by the review team. It was always expected that, with a room of sixty people, a lot of information, data, opinions and perspectives would emerge. It was also expected that such perspectives wouldn't be in total accord, so consensus wasn't expected. The critical exercise was to listen to those present in a manner that could capture the possible role, functions and priorities for the MHC going forward. This was purposefully framed in a convening question: *What is the unique and impactful role that the Mental Health Commission can play to improve the mental health system and the mental health and wellbeing of the people of NSW?*

It is fair to assume that participants also expressed their overall frustrations, desires and the perceived and real gaps of the mental health system in general, beyond that of just the contribution of the MHC.

### Lived experience

The voice of those with lived experience not being heard and then integrated into the design and operation of the mental health system – including related system/sectors - was at the forefront in the minds of many in the forum. Despite the efforts of many in the system to consider those with lived experience, including those present at the forum, it would appear that some consumers and carers still feel the system isn't aligned to their needs, or if it is aligned, not communicated or visible to them. Also, as already specifically addressed in this report, their perception of the system not listening was 'played out' in the forum when they spoke of feeling shut down or shut out during table discussions. Accordingly, the voice of those with lived experience being heard and sincerely acted upon would be seen, by many, as the most unique and impactful contribution by the MHC.

### Supporting authority and engagement

When comparing the present framework as against what emerged from the Forum, the MHC presently seems to have a wide-ranging remit. The conceptual framework provided in this report is more focused and representative of the contributing insights from the participants. During our interviews and the forum, participants observed that it is difficult to deliver a large remit in an issue which reaches across a complex system, and has significant linkages into other systems and sectors, including drug and alcohol, disability, justice, housing and education to name a few. Furthermore, the lack of a clear authority across government and non-government can hamper the effectiveness of the MHC to undertake its role and functions and again participants were seeking clarity as to such authority. By this is meant that to what extent does the MHC, or should the MHC, have an authority to request information or data, for example, and/or direct certain action to be undertaken by others.

Even with a more focused remit, the MHC would still require a supporting authority. The forum participants recognised this through asking where the responsibility in the system lies for the delivery of effective outcomes, and how the component parts of the system are kept accountable for such delivery. They felt the MHC could contribute to how responsibility and accountability operates in the system, but that it would need to be supported by possible legislative provisions, structural positioning in the broader public sector, and clear and unambiguous positioning of leadership. Whether such a contribution lies with the MHC or not will be decided through other discussions in the context of the machinery of government, but the essence of

the concern expressed is that both the responsibility and accountability to deliver effective mental health outcomes isn't apparent to stakeholders or considered effective.

Finally, simple reliance on authority is not always effective either and any proactive, reactive and holistic addressing of mental health will require collaborative and effective engagement across many systems and sectors. Achieving sustainable outcomes requires superior collaboration skills, together with behaviours and processes which support effective co-design that both embraces and leverages the voice of consumers and carers.

The conceptual framework provided brings together the insights and desires of the Forum participants.

## APPENDIX "A"

### Building the context for the forum

Reos Partners proposed to the review team a process that ensured the facilitators could as much as possible be immersed in the landscape that that is the present context of the Mental Health Commission. This assisted us to co-design the Forum with the Reference Group and review team and provided an understanding of the different perspectives and perceptions alive in the system. In its work, Reos Partners uses an approach that involves carefully designed processes that are simultaneously **systemic** (work on the whole not just the parts), **participative** (involve the stakeholders in the solution), and **emergent** (co-create new ways of thinking, relating and working).

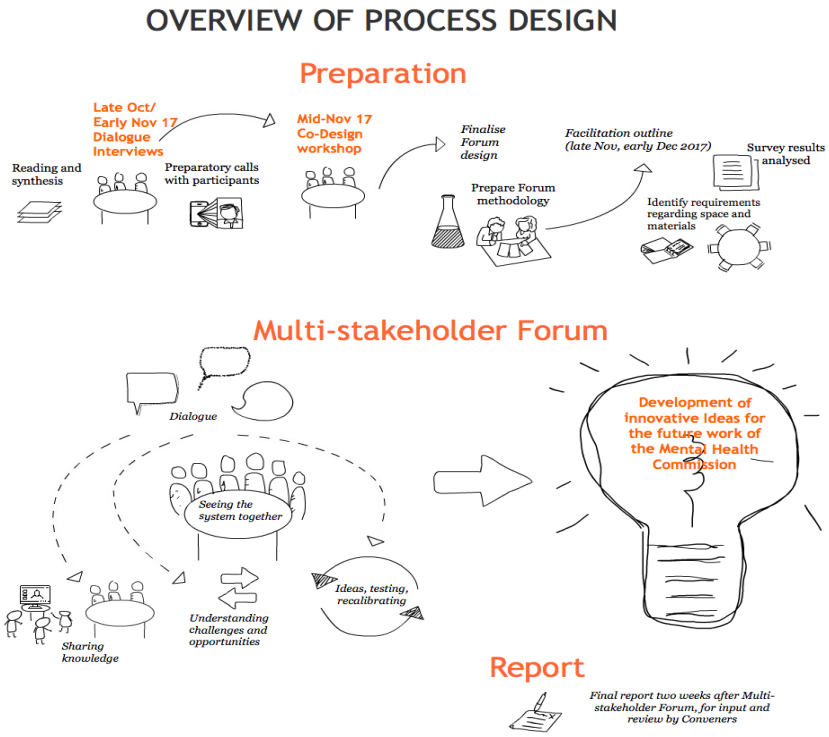
The following diagram was included in the proposal and gives an understanding of overall process used to deliver the desired outcome - from the interview process, through to the co-design with the Reference Group, to the Forum.

In this instance, the survey results weren't available as an input into the workshop, but we don't believe this caused any difficulty to achieve the final outcome.

## Interviews and finding the Convening Question

A total of 11 dialogue interviews were conducted with some being with more than one person, so a total of fourteen people were spoken to. The interviews proved to be valuable for the facilitators as it allowed greater appreciation of the different perspectives in the mental health system, and also the present and possible future contribution of the MHC within the system. In a sense, it allowed the facilitators to consider what to expect in the forum and to seek the advice of the Reference Group in possible ways of designing the day to meet different and possible eventualities. The interviews also gave space for the interviewees to consider the hopes and desires for the forum and even the future of the MHC. Without the interviews, the facilitators wouldn't have been as well prepared for the co-design meeting with the Reference Group and the further design and facilitation of the forum.

Some of the key insights that emerged from the interviews and that assisted the co-design process and building the knowledge of the facilitators included the importance of the system having a person centred approach; de-stigmatising mental health in the community; the need for working collaboratively across sectors in delivering good outcomes; how to build greater prevention and early intervention; what further authority does the MHC need to undertake its role and, the interaction with social determinants involved with mental health. Interviewees were also interested that the forum could assist in getting greater clarity in the role for MHC; a broad consensus/agreement for the future direction; and, how can the MHC increase its influence.




When working with multi-stakeholder groups, Reos Partners tries to construct a convening question, a question designed to resonate with stakeholders and to provide an intent for, in this case, the Forum. It was from the interviews that we were able to develop a convening question which we felt expressed the intent of the Forum, and, importantly, focused the thinking of the participants in accord with the desired outcome of the review team.

The convening question was first tested with the Reference Group who agreed it expressed the desired intent and outcome of the Forum. The convening question was:

*What is the unique and impactful role that the Mental Health Commission can play to improve the mental health system and the mental health and wellbeing of the people of NSW?*

One of the key themes that emerged from the interviews was the complexity of the NSW mental health system, and the different roles and responsibilities of both government and non-government agencies/services that contribute to gaining a clear position for the MHC. By seeking a 'unique' role for the MHC meant it would be a role no one else would be best positioned to undertake; or would want to undertake; or would be appropriate or capable to undertake. In seeking the role to be one which is **also** 'impactful' means it would have the potential to cause the shift needed for the mental health system to positively influence the mental health and wellbeing of the people of NSW.

### Co-design process with Reference Group

On 27 November 2017, the facilitation team worked with the Reference Group to understand further what was needed to design the most valuable Forum experience for the participants and meet the desired outcomes of the review team. What we wanted to ensure was the forum not getting stuck with participants merely wanting to replay what was wrong with the present system, but rather be dynamic and generative as what could be possible for the future of the MHC and its positive contribution to the system. So, the challenge was to design into the day the ability for participants - using a driving analogy - to 'glimpse' in the rear vision mirror of what has gone on before, but with the intent of understanding how that contributes to a new horizon through the front windscreen. To this end, the day was designed to allow time for people to work with each other and talk about their experiences but in the context of how it can contribute to moving forward.

Another key insight from the co-design time with the Reference Group was how to provide a platform to generate discussion, given it was only a limited time with the participants. To this end the Reference Group mentioned the ten Domains laid out in *Living Well* paper.

1. Planning for our future
2. Making it local
3. Getting in earlier
4. Putting people first
5. Providing the right type of care
6. Better responses
7. Care for all
8. Supporting reform
9. Governance of mental health within New South Wales
10. Broader Context of Reforms

These ten Domains created the platform on which to commence discussion for the key outcomes for the Forum to build the future role, functions and priorities of the MHC.

## APPENDIX "B"

### Data on functional areas as per notes made by participants

| **System engagement and collaboration (18 votes)**<br>(Note: a lot coming up around those with lived experience being in influential positions) | **Community engagements (12 votes)** | **Strategy (10 votes)** |
|---|---|---|
| • Promote holistic recovery – encompassing housing, education, employment, community corrections<br>• Facilitating collaboration across the sectors<br>- support for sectors to collaborate within LHD's<br>- forums<br>- 'how to' kit<br>- bring key people from LHD's, NGO's for training<br>• Enhancing collaboration<br>• Coordinate stakeholders & services to collaborate in achieving strategic objectives and drive reform eg. professional bodies; regulatory bodies; lived experience<br>• System engagement and collaboration | • The MHC meaningfully supports active engagement of community leaders to inform specific 'partnerships for outcomes'. | • Whatever functions Mental Health Commission do land on, it needs to be done so it doesn't create more bureaucracy and add onerous requirements<br>• Strengthening review of funding for mental health – the Act could enable MHC to hold LHD CEO's and Boards accountable for mental health funding<br>• Review of quality of all mental health services – public & NGO<br>mental health line;<br>community managed organisations;<br>public mental health inpatient and community;<br>peer run; publicly reported<br>Mental Health Commission write to CEO, Boards and mental health Directors and acknowledge when they achieve something well<br>• Set priorities and monitor government agency performance against annual priorities<br>• Develop vision and strategic plan for NSW mental health services<br>• Strategic focused – planning and monitoring of delivery with support of DPC delivery unit |

| **Planning and monitoring (2 votes)** | **Consumer/Carer Outcomes (44 votes)**<br>• Co design participation<br>(Note: want greater involvement of lived experience in leadership positions together with participation in co-design) | **Data collection and dissemination (14 votes)**<br>• Measure<br>• Collect and share<br>• Benchmarking and advocacy<br>• Quantitative and qualitative<br>• Commission (innovation) |
|---|---|---|
| • Coordinate/map service system<br>• System engagement – business; government; plan with indicators<br>• Mapping services and matching funding to need<br>• Defining and sharing best practice/standards in priority areas eg. trauma informed care<br>• Planning and monitoring | • Monitor outcomes for consumer/carers (promote consumer/carer experience tools)<br>• Identify and support peer champions for co-design purposes and mandate and materially support voice of lived experience in reform and commissioners and co-design<br>• I would like the words "trauma oriented care" included somewhere.<br>• Trauma informed and recovery focused practices to be included in data collection – report from mental health services how they are implementing TIC and Recovery focus into service development delivery, monitoring and review processes.<br>• The MHC meaningfully supports active engagement of community leaders to inform specific partnership s for outcomes.<br>• Community engagement<br>• Leaders lived experience voices @ all levels of service design and delivery. They should be the leaders of services and changes<br>• Support the peer workforce and community/carer leaders<br>• | • Ensure evidence based & data driven decision making underpins/informs mental health reform<br>• The MHC prioritises data and research that informs measurable improvements to access & equity for divers/minority populations in NSW<br>• Promote and drive best practice<br>• Develop and streamline and integrate outcome data sets across whole of government<br>• Ensure independent evaluation and monitoring of mental health services<br>• Clearinghouse – the go to place for information about effective programs/services/activities eg. peer worker page that the MHC already has<br>• To create change – source, develop and deliver evidence-based credible advice (to government) based on community input; financial/actuarial analysis; research, etc.<br>• Regular transparent reporting of mental health outcomes eg. are we making a difference?<br>• Encourage and support data linkage (beyond Health too)<br>• Measure and publish performance and $/human resources – collaborate with BHI;<br>• MHC needs access to the data and authority to comment<br>• Benchmarking and advocacy |

| **Promote innovation (9 votes)** | **Independent voice (21 votes)** | **Advocacy (15 votes)**<br>• A voice for the system<br>• Consultation lobbying<br>• Voice of lived experience<br>• Interagency – acknowledge the past |
|---|---|---|
| • Promoting a clearinghouse for efficient and effective practices that are working well so that they can be implemented in other services without the need to 'reinventing' the wheel.<br>• Promoting best practice and innovation<br>• Support the government with reducing barriers and creating opportunities for local innovation and activity.<br>• Commissioning innovation funding to achieve strategic objectives<br>• Commissioning innovation, research and evaluation | • Be an independent voice<br>• Be an independent voice in Premier & Cabinet led by Premier<br>• Independent voice reporting to Premier and Cabinet<br>• Report to the Premier not the Minister for Mental Health<br>• Making Mental Health Council accountable to Parliament to track dollars and be an independent voice<br>• Regular transparent reporting of Mental Health budget expenditure to Parliament (tracking the money)<br>• Mental health Commissioner and Deputy Mental Health Commissioner to have personal experience of mental illness as a consumer and/or carer | • Provide advocacy for inter-agencies to work together for those needing mental health services eg. DEC, Health, Justice, Housing, etc.<br>• Highlighting deficiencies in the system<br>• Engaging with NDIS<br>• Consultation and lobbying/advocacy eg. national programs, policy development, cross sector - using consumer and carer voices for advocacy if conflict occurs<br>• Reinforce and clarify messages about risk and confidentiality (ie. it is OK to share information; involve carers)<br>• Support and listen to OV's<br>• Acknowledge past to move forward<br>• Memorial for all people buried on all NSW mental health hospitals<br>• Advocate for the voice of lived experience as leaders in policy and service development across whole of government.<br>• Advocate carers/consumer voices challenging stigma.<br>• Unique – ensure lived experience eg. service users which includes the persons experiencing mental distresses and their family/friends "carers". Also they inform research – equity – research teams are the ones to set the measures, do the evaluations and their feedback counts as equally as any other measures or evaluations and this change and reform service provision.<br>• Trauma informed care and Recovery Practices cannot be just jargon or tick box. |

## APPENDIX 'C'

### Results of Involvement Model process as per feedback from participants

1. **Accountable** and **responsible** for outcome delivery
2. **Shared responsibility** for outcome delivery through **collaboration**
3. **Not responsible** for outcome delivery but can **add value** through **co-operating** with others
4. **No** obvious **responsibility** or contribution to make in delivering outcomes
5. **Other** type of involvement (specify and describe)

| Proposed function | Type of involvement (1-5) | Unique? How? | Impactful? How? |
|---|---|---|---|
| Systems engagement and collaboration | 2 | Independent, direct line to government | Voice of community, voice of consumer, data and evidence |
| Community engagement | 1 | Core focus of MHC | Building credibility and evidence |
| Strategy | 2 | Whole of system perspective | Ownership of strategy by the system |
| Planning and monitoring (data collection and dissemination) | 2<br>3 (add value by advocating innovation) | • Whole of system perspective<br>• Advocacy to government and whole of system perspective | • Promotes excellence<br>• Credible evidence base |
| Consumer and carer involvement | 1 | Direct access, link between CMO & Govt | Credible evidence, consumer voice to Govt. |
| Promote innovation | 2 | Showcasing innovation | Credibility – make system change easier for people in coal face |
| Be an independent voice | 1 | MHC is independent | Speak freely and frankly – credible |
| Advocacy | 1 | MHC is independent | Speak freely and frankly - credible |

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4. **No** obvious **responsibility** or contribution to make in delivering outcomes
5. **Other** type of involvement (specify and describe)

| Proposed function | Type of involvement (1-5) | Unique? How? | Impactful? How? |
|---|---|---|---|
| System engagement and collaboration | 2 | Between sectors. In partnership | Report to Premier |
| Community engagement | 1 | Legislated – breadth | Known and heard |
| Strategy | 2 | CAC, Reports (eg MH Carers NSW),<br>Whole of Government | Support disruptive strategists |
| Panning and monitoring | 1 | Strategic Plan -> monitor and report. Power to enforce? | Living Well – can we see outcomes? |
| Ensure consumer carer focus | 1 | Legislated LE commissioner CAC. Workforce | Leadership equity and voice |
| Data collection and dissemination | 2 | Access – legislated power to demand data. Standardisation? | Power to collect and report |
| Promote innovation | 2 | Leadership across State. Driver. | Set targets, goals, source funding. Shift to consumer and carer |
| Be an independent voice | 1 | Focus, legislated. Strength and fearless | High profile. High public awareness. Be engaged. leadership |
| Advocacy | 2 | Access to decision makers. Effective channels. | Regular communication and public issues |

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3. **Not responsible** for outcome delivery but can **add value** through **co-operating** with others
4. **No** obvious **responsibility** or contribution to make in delivering outcomes
5. **Other** type of involvement (specify and describe)

| Proposed function | Type of involvement (1-5) | Unique? How? | Impactful? How? |
|---|---|---|---|
| System engagement and collaboration | 2 (collaborating partners) | Bipartisan; system rather than service view | Spans entire system - unique |
| Community engagements | 2 (consumers, services; minister) | System rather than service lens | Consistent principles, meaningful engagement |
| Strategy | 1 | Overarching view (beyond health) | Encompasses broader than health; longer term view. Can move beyond 'delivery' remit – big picture; change longer term |
| Planning and monitoring | 2 (services, Minister) | Consistency (benchmarking) | Collaboration – joint planning |
| Consumer/Carer focus | 2 (services) | Fidelity and meaningful engagement | Consumer/carer voice. Links to strategic plan/reform agenda |
| Data collection and dissemination | 3 (data collection)<br>2 (dissemination, inform) | MHC adds value through consistency measures | Independent and strategic view |
| Promote innovation | 1 | Overarching view, cross-sector; beyond delivery focus | Independence, consumer driven; bring in consumer voice |
| Independent voice | 2 (services, CMO's) | MHC brings independent view; strategic view | Credible authority |
| Advocacy | 2 (services, CMO's) | MHV brings independent view, strategic view | Credible authority |

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3. **Not responsible** for outcome delivery but can **add value** through **co-operating** with others
4. **No** obvious **responsibility** or contribution to make in delivering outcomes
5. **Other** type of involvement (specify and describe)

| Proposed function | Type of involvement (1-5) | Unique? How? | Impactful? How? |
|---|---|---|---|
| System engagement and collaboration | 1 (if MHC is under Premier & Cabinet) | Yes | Issue dependent, important reform potential |
| Community engagements | 1 | No | Impactful if done well, issue dependent |
| Strategy | | | |
| Planning and monitoring | 1 (for monitoring)<br>2 (for planning) | Yes | Monitoring should be a major function of the MHC |
| Consumer/Carer focus | 2 | No | MHC could have a leader role |
| Data collection and dissemination (outcomes, benchmarking) | 2 | No | Making available to public |
| Promote innovation | 1, 2, or 3 depending on context and capacity | No | Leading important change |
| Independent voice | 1 & 5 (will require legislative change) | Yes | An independent voice with Premier and Cabinet |
| Advocacy | 1 (if independent) | No | Eg. complaints re-system issues |

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2. **Shared responsibility** for outcome delivery through **collaboration**
3. **Not responsible** for outcome delivery but can **add value** through **co-operating** with others
4. **No** obvious **responsibility** or contribution to make in delivering outcomes
5. **Other** type of involvement (specify and describe)

| Proposed function | Type of involvement (1-5) | Unique? How? | Impactful? How? |
|---|---|---|---|
| System engagement and collaboration | 2 | Strong leadership with sectors | Trusted and supportive |
| Community engagements | 2 | | |
| Strategy | 1 | Strong leadership with sectors | Cross departmental ministerial functions |
| Planning and monitoring | 1 | Strong leadership with sectors | Trusted independent and supportive |
| Consumer/Carer focus | 2 | Strong leadership with sectors | |
| Data collection and dissemination | 2 | Strong leadership with sectors | |
| Promote innovation | | | |
| Independent voice | | | |
| Advocacy | 2 | Seen as being trusted and independent | |
| Distribution of funds | 1 | Custodianship | |
| Consolidation of funds, revenue and equity of distribution | 1 | | |

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3. **Not responsible** for outcome delivery but can **add value** through **co-operating** with others
4. **No** obvious **responsibility** or contribution to make in delivering outcomes
5. **Other** type of involvement (specify and describe)

| Proposed function | Type of involvement (1-5) | Unique? How? | Impactful? How? |
|---|---|---|---|
| System engagement and collaboration | 3 | | Authoritative scorecard |
| Community engagements | 3 | Group with no voice | Advocacy, understanding |
| Strategy | 3 | Merging service strategies | Enable services to work together |
| ~~Planning~~ and monitoring | 2/3 | Monitoring achievement | Benchmarking transparent |
| Consumer/Carer focus | 2 | End-users and carers communities | Shining the light |
| Data collection and dissemination | 2 | Whole of system | Speak to government and community, accountability |
| Promote innovation | 3 | Promoting good innovation | Increase best practice |
| Independent voice | 1 | Official scorecard | Line in the sand |
| Advocacy | | | |

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3. **Not responsible** for outcome delivery but can **add value** through **co-operating** with others
4. **No** obvious **responsibility** or contribution to make in delivering outcomes
5. **Other** type of involvement (specify and describe)

| Proposed function | Type of involvement (1-5) | Unique? How? | Impactful? How? |
|---|---|---|---|
| System engagement and collaboration | 2 | Mapping the landscape | |
| Community engagements | 3 | | |
| Strategy | 1 | | |
| Planning and monitoring | 1 | | |
| Consumer/Carer focus | 2 | | |
| Data collection and dissemination | 5 | Advocate for access to data | |
| Promote innovation | 2 | Not unique to MHC | Avoiding duplication |
| Independent voice | 1 | Depends on funder | |
| Advocacy | 2 | If independent | Cross-sector advocating together in a meaningful way |

1. **Accountable** and **responsible** for outcome delivery
2. **Shared responsibility** for outcome delivery through **collaboration**
3. **Not responsible** for outcome delivery but can **add value** through **co-operating** with others
4. **No** obvious **responsibility** or contribution to make in delivering outcomes
5. **Other** type of involvement (specify and describe)

| Proposed function | Type of involvement (1-5) | Unique? How? | Impactful? How? |
|---|---|---|---|
| System engagement and collaboration | 2 | Independent oversight | |
| Community engagements (chamber of commerce) | 1 (system level) | Perception of trust with the community | Travel to areas – broader engagement and promotion of events |
| Strategy | 1 | Long term planning -> | Long term planning; change from reactive to proactive |
| Planning and monitoring | 1 or 2 | Collaborating with NSW Mental, Mental Health Plan | To align with NSW Mental Health Plan |
| Consumer/Carer focus | 2 | Evidence exists of how they have achieved this | |
| Data collection and dissemination | 3 | | |
| Promote innovation | 2 | Communication strategy<br>Give credibility to complimentary and diverse therapies | New media – skype<br>Give credibility to complimentary and diverse therapies |
| Independent voice | 1 | | |
| Advocacy | 1 | Communication strategy | New media - skype |

1. **Accountable** and **responsible** for outcome delivery
2. **Shared responsibility** for outcome delivery through **collaboration**
3. **Not responsible** for outcome delivery but can **add value** through **co-operating** with others
4. **No** obvious **responsibility** or contribution to make in delivering outcomes
5. **Other** type of involvement (specify and describe)

| Proposed function | Type of involvement (1-5) | Unique? How? | Impactful? How? |
|---|---|---|---|
| System engagement and collaboration | 2 | Build framework across sector and government to improve wellbeing | Across sectors and government (+expertise) |
| Community engagements | 2 | | |
| Strategy | 1 | | |
| Planning and monitoring | 2 | | |
| Consumer/Carer ~~focus~~ involvement & leadership | 1 | People of lived experience in all levels and areas | Development of lived experience workforce |
| Data collection and dissemination (data driven feedback/collection) | 1 | | |
| Promote innovation | 3 | Showcase and share (facilitate sharing) | Cross fertilizing innovation and knowledge |
| Independent voice | 1 | | |
| Advocacy | 1 | Independent voice led by voice of lived experience | Change the Act – report to Premier |

## APPENDIX 'D'

### Interviewees to assist co-design of forum

Robyn Bale – A/Executive Director, Learning and Wellbeing, Department of Education

Jenna Bateman – Chief Executive Officer, Mental Health Coordinating Council

Tom Brideson - State-wide Coordinator, NSW Aboriginal Mental Health Workforce Program

Dr Richard Buss - General Manager, Mental Health & Drug and Alcohol Service and Stream Services, Northern NSW Local Health District

Dr David Chaplow - Expert Reviewer

Emily Frankel – Policy Officer, Department of Premier and Cabinet

Jonathan Harms - Chief Executive Officer, Mental Health Carers NSW

Corinne Henderson - Principal Adviser, Mental Health Coordinating Council

Dr Claire Jones - Director, Mental Health Services, South Western Sydney Local Health District

Chris Leach – Office of the Deputy Secretary, Disability Operations, Department of Family and Community Services

Dr Karin Lines - Executive Director, Mental Health Branch

Commissioner Catherine Lourey - Mental Health Commission of NSW

Rebecca Magoffin - Principal Policy Officer, Department of Family and Community Services

Paul McKnight - Executive Director, Strategy and Policy Branch, Department of Justice

## APPENDIX 'E'

## Forum attendees

| | | | |
|---|---|---|---|
| Kathleen | Schelling | Mental Health Network Manager | Agency for Clinical Innovation |
| Karen | Price | Deputy CEO | Aids Council of NSW (ACON) |
| Joumana | Khoury | Clinical Nurse Specialist, Bungarribee House & former Chair of the ACMHN Greater Western Sydney Branch | Australian College of Mental Health Nurses |
| Prof. Luis | Salvador-Carulla | Head, Centre for Mental Health Research and Research School of Population Health | Australian National University |
| Eileen | McDonald | Consumer representative | Being - Mental Health & Wellbeing Consumer Advisory Group |
| Sarah | Dauncey | Consumer representative | Being - Mental Health & Wellbeing Consumer Advisory Group |
| Paula | Hanlon | Consumer representative | Being - Mental Health & Wellbeing Consumer Advisory Group |
| Sunny | Hemraj | Consumer representative | Being - Mental Health & Wellbeing Consumer Advisory Group |
| Aloka | Wylde | Consumer representative | Being - Mental Health & Wellbeing Consumer Advisory Group |
| Irene | Gallagher | Chief Executive Officer | Being - Mental Health & Wellbeing Consumer Advisory Group |
| Fayez | Nour | Chair | Being - Mental Health & Wellbeing Consumer Advisory Group |
| Nicole | Cockayne | Director Discovery and Innovation | Black Dog Institute |
| Hilary | Rowell | Director of Strategic Relations | Bureau of Health Information |
| Dr. Kim | Sutherland | Acting Chief Executive | Bureau of Health Information |
| Carolina | Simpson | Policy & Development Officer | Carers NSW |

| | | | |
|---|---|---|---|
| Prof. David | Perkins | Director | Centre for Rural and Remote Mental Health |
| Liza | Loobeek | Patient Safety Analyst | Clinical Excellence Commission |
| Dr. Phillip | Snoyman | Director State-wide Services | Corrective Services NSW |
| Pauline | Kotselas | Leader, Psychology and Wellbeing Services | Department of Education |
| Katrina | Worrall | Principal Psychologist | Department of Education |
| Rebecca | Magoffin | Manager, Strategic Policy - Child and Family | Department of Family and Community Services |
| Amanda | Duvall | Policy Officer, Offender Strategy, Strategy & Policy Branch | Department of Justice |
| Pamela | Rutledge | Chief Executive Officer | Flourish Australia |
| Rhonda | Loftus | Executive Director, Mental Health Portfolio | Health Education & Training Institute NSW |
| Eugene | McGarrell | General Manager, Health & Community Engagement | iCare |
| Damien | Eggleton | Acting Director Forensic Mental Health | Justice Health & Forensic Mental Health Network |
| Jonathan | Harms | Chief Executive Officer | Mental Health Carers NSW |
| Mary | Hampshire | Carer representative | Mental Health Carers NSW |
| Peter | Heggie | Carer representative | Mental Health Carers NSW |
| Jenny | Learmont | Carer representative | Mental Health Carers NSW |
| Sandra | McDonald | Carer representative | Mental Health Carers NSW |
| Anne | Stedman | Carer representative | Mental Health Carers NSW |
| Karen | Burns | Deputy Commissioner, Chair of MHCC | Mental Health Commission of NSW |
| Jenny | Crocker | Manager, Communications and Stakeholder Relations | Mental Health Commission of NSW |
| Tim | Heffernan | Member, Community Advisory Council | Mental Health Commission of NSW |
| Fay | Jackson | Deputy Commissioner | Mental Health Commission of NSW |
| Catherine | Lourey | Commissioner | Mental Health Commission of NSW |
| Brian | Pezzutti | Member, Community Advisory Council | Mental Health Commission of NSW |
| Jenny | Reid | LD Manager | Mental Health Coordinating Council |
| Marie | Fox | Senior Advisor Business Development | MIND Australia |

| | | | |
|---|---|---|---|
| Larissa | McLean | Manager Performance, Analysis and Reporting | Ministry of Health |
| Vincent | Ponzio | Director MH-CYP, Mental Health | Ministry of Health, Mental Health Child and Young People |
| Maureen | Lewis | Deputy CEO | National Mental Health Commission |
| Judi | Higgin | Chief Executive Officer | New Horizons |
| Natalie | Cook | NSW/ACT PHN Coordinator | North Sydney PHN |
| Lyndy | Urane | Acting District Nurse Manager Mental Health, Drug & Alcohol | Northern NSW Local Health District |
| Tom | Brideson | State-wide Coordinator | NSW Aboriginal Mental Health Workforce Program |
| Elyse | Cain | Policy Lead in Health, Mental Health and Children and Families | NSW Council of Social Services |
| Emily | Frankel | Acting Principal Policy Officer | NSW Department of Premier and Cabinet |
| Julian | Cornelius | Director, Health | NSW Treasury |
| Rob | Ramjan | Chief Executive Officer | One Door Mental Health |
| Dr. Kerrie | Buhagiar | Director of Service Delivery | Reachout.com |
| Dr. Sarette | Lee | NSW Branch Committee Member | Royal Australian & New Zealand College of Psychiatrists |
| Dr. Nick | O'Connor | RANZCP Board Member | Royal Australian & New Zealand College of Psychiatrists |
| Jack | Heath | Chief Executive Officer | SANE Australia |
| Dr. Claire | Jones | Director, Mental Health Services | South Western Sydney Local Health District |
| Maria | Cassaniti | Centre Manager | Transcultural Mental Health Centre |
| Keith | Hamilton | Senior Minister, Group CEO | Uniting Recovery |
| Elizabeth | Priestley | Chief Executive Officer | WayAhead |
| Bill | Campos | Senior Clinical Psychologist and Head of Mental Health | WentWest |

# APPENDIX 6
# STAKEHOLDER CONSULTATION SUMMARY

# REVIEW OF THE MENTAL HEALTH COMMISSION OF NEW SOUTH WALES

## STAKEHOLDER CONSULTATION SUMMARY

Approximately 900 stakeholders including people with lived experience of mental illness, their families and carers and stakeholders from the mental health, broader health, government, non-government and community sectors were consulted through:

- Face to face interviews and workshops - with 80 stakeholders
- A multi-stakeholder forum - with 60 stakeholders
- An online survey - receiving 753 responses
- Written submission - from 10 stakeholders

## Interviews and workshops – schedule

Between October 2017 and February 2018 (five-month period), the Reviewer convened 20 interview and roundtable consultation sessions with the following participants:

- 14 August 2017 – Outgoing Commissioner John Feneley (2012-2017)
- 16 August 2017 – Incoming Commissioner Catherine Lourey (2017-current)
- 3 October 2017 – CEO of the National Mental Health Commission (1 participant)
- 3 October 2017 – CEOs and board members of Being (Mental Health & Wellbeing Consumer Advisory Group) and Mental Health Carers NSW (6 participants)
- 3 October 2017 – CEO and board members of the Mental Health Coordinating Council (3 participants)
- 4 October 2017 – CEOs of key partners: Being, Beyondblue, Mental Health Carers NSW, WayAhead (4 participants)
- 4 October 2017 – NSW Health: Clinical Excellence Commission, Health Education and Training Institute, Northern NSW LHD, South West Sydney LHD (4 participants)
- 4 October 2017 – NSW Government: Department of Premier and Cabinet, Department of Family and Community Services, Department of Education, Department of Justice, Justice Health and Forensic Mental Health Network (6 participants)
- 5 October 2017 – Consumers and carers (9 participants including CEO of MHCN)
- 6 October 2017 – Incoming Commissioner and Executives of the Mental Health Commission of New South Wales (9 participants)
- 21 November 2017 – National and NSW Branch executives of the Royal Australian and New Zealand College of Psychiatrists (3 participants)
- 23 November 2017 – academics (3 participants)
- 23 November 2017 – Secretary of NSW Health (1 participant)
- 11 December 2017 – Department of Family and Community Services (3 participants)
- 13 December 2017 – Chief Psychiatrist of NSW Health (1 participant)
- 13 December 2017 – Youth representatives and service providers (12 participants)
- 14 December 2017 – Legal & Regulatory Services, NSW General Counsel (1 participant)
- 14 December 2017 – Aboriginal representatives (9 participants)
- 9 January 2017 – Commissioner of the Queensland Mental Health Commission (1 participant)
- 21 February 2018 – Chair of RANZCP NSW Branch (1 participant)

## Multi-stakeholder forum

A collaborative multi-stakeholder forum focusing on Part B of the Review brought together 60 invited representatives of consumers and carers, NSW Government agencies, the NGO/CMO sector and other organisations in December 2017. A full attendee list is available at Appendix 5. Multi-stakeholder Forum Outcomes Report.

## Online survey

An online survey was promoted widely to encourage broad stakeholder participation. 753 responses were received. 40% were from representatives of organisations and 60% from individuals. Among individuals 24% were people with lived experience of mental illness, and 21% were family members or carers of a person with mental illness.

## Written submissions received

A submission was received from the outgoing inaugural Commissioner of the Mental Health Commission of New South Wales and attached as an appendix to the report. The other nine submissions were received during the eight-week public consultation period from the following stakeholders:

- 2 individual members of the public
- 2 clinicians and representatives of a health service (headspace and NSW Health)
- 1 representative of NSW Government agencies (Office of the NSW Small Business Commissioner)
- 4 other stakeholders (academics, peak bodies and non-government organisations):
    - AIDS Council of NSW (ACON)
    - Flourish Australia
    - Mental Health Carers NSW (MHCN)
    - The Royal Australian & New Zealand College of Psychiatrists, NSW Branch (RANZCP)

## TARGETED STAKEHOLDER GROUPS

The Commission's multiple stakeholder groups were invited to contribute throughout the process. These key stakeholders included:

### Mental Health Sector—Peak organisations

These non-government organisation advocacy groups have allied interest in the mental health and wellbeing of consumers and carers. Some also circulated the online survey to their members to seek feedback from with people with lived experience of mental illness, their families and carers.

- BEING—Mental Health & Wellbeing Consumer Advisory Group
- Mental Health Australia
- Mental Health Carers NSW
- Mental Health Coordinating Council (MHCC)

## NSW Government organisations

Public sector agencies that cooperate with the Commission were engaged throughout this review, including:

- Aboriginal Affairs NSW
- Advocate for Children and Young People (ACYP)
- Department of Education
- Department of Family and Community Services (Housing NSW)
- Department of Justice (Corrective Services NSW, Juvenile Justice, Legal Aid)
- Department of Premier and Cabinet
- First Responder agencies (NSW Ambulance, St John NSW, Police, Rural Fire Services, NSW SES)
- icare (Insurance & Care NSW)
- Mental Health Review Tribunal
- NSW Coroner's Court
- Principal Official Visitor
- SafeWork NSW
- NSW Treasury

## NSW Health

The Ministry of Health, in particular the Mental Health Branch, the four major pillars and LHDs were extensively consulted throughout this review for feedback on the Commission's performance and suggestions to improve the alignment of the Commission's work to NSW Health's strategic priorities.

- Agency for Clinical Innovation (ACI)
- Bureau of Health Information (BHI)
- Clinical Excellence Commission (CEC)
- Health Education & Training (HETI)
- Local Health Districts and Networks, Chief Executives and Board Chairs
- Local Health Districts and Networks, Directors of Mental Health
- Medical Services Committee of NSW

## Research Sector

The Commission developed a network of academic and research partners through commissioning various projects over the last five years. Representatives were engaged from these institutions:

- Black Dog Institute (UNSW)
- Brain and Mind Centre, University of Sydney
- Centre for Rural and Remote Mental Health
- Centre of Research Excellence in Mental Health and Substance Use (CREMS)
- Department of Developmental Disability Neuropsychiatry (3DN), University of NSW
- National Drug and Alcohol Research Centre (NDARC)
- NeuRA (Neuroscience Research Australia)
- University of Newcastle
- University of Wollongong
- Hunter Institute of Mental Health

## Not-for-profit and Community Managed Organisations

The Commission's extensive NGO community were consulted, including representatives from:

- Aftercare
- Beyond Blue
- Blue Knot Foundation
- Butterfly Foundation
- Community Care Northern Beaches (CCNB)
- Flourish Australia (RichmondPRA)
- Grand Pacific Health
- Grow NSW
- Headspace
- Lifeline
- MIND Australia Ltd
- Mission Australia
- NEAMI National (North Eastern Alliance for the Mentally Ill)
- National Association for Loss and Grief (NALAG)
- New Horizons
- One Door—Carers Program
- Reachout.com
- Parramatta Mission—UnitingRecovery
- WayAhead
- Others as may be identified (domestic violence, homelessness, youth, older persons organisations)
- SANE Australia
- Suicide Prevention Australia

## Specific communities

The Commission's stakeholders that target areas of disadvantage or challenge in relation to health outcomes for specific diverse or minority communities were consulted, including:

- Aboriginal Health and Medical Research Council
- Aboriginal Mental Health Workforce Program
- Alzheimer's Australia
- Australian Psychological Society (APS)
- Australian College of Mental Health Nurses (ACMHN)
- Council on the Ageing NSW
- Cultural Perspectives Group
- National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH)
- National Disability Insurance Agency
- NSW Council for Intellectual Disability
- NSW Multicultural Health Communications Service
- The Royal Australian College of General Practitioners (RACGP)
- Transcultural Mental Health Centre
- AIDS Council of NSW (ACON)
- Family Planning NSW
- Network of Alcohol and other Drugs Agencies (NADA)

- NSW Council of Social Services (NCOSS)
- Women's Health NSW
- Youth Action

### General consumer groups

Other general consumer groups were also consulted, including:

- Carers NSW
- Community Relations Commission NSW
- Health Consumers NSW
- NSW Consumer Advisory Groups

### Other groups

The Commission also liaises with national associations and federal government agencies on various mental health related initiatives and projects, and the following were consulted:

- Australian Bureau of Statistics (ABS)
- Australian Institute of Health and Welfare (AIHW)
- National Mental Health Commission (NMHC)
- New South Wales Nurse and Midwives' Association
- Australian College of Mental Health Nurses
- Australian and New Zealand Mental Health Association
- Primary Health Networks

### Mental Health Commission of New South Wales

Lastly, the Commission assisted the review by circulating the online survey to their own-led networks, including:

- Carers Group (MHC NSW)
- Consumer Led Research Network
- Health Justice Partnerships Community of Practice
- Lived Experience Group (MHC NSW)
- Open Dialogue Interest Group
- Pharmacotherapy in Mental Health Advisory Group (MHC NSW)
- Suicide Prevention Advisory Group
- Wellbeing Collaborative

# APPENDIX 7
# SUMMARY OF KEY ORGANISATIONS AND AGENCIES IN THE NSW MENTAL HEALTH SYSTEM

# APPENDIX 7: SUMMARY OF KEY ORGANISATIONS AND AGENCIES IN THE NSW MENTAL HEALTH SYSTEM

| Organisational Type | Organisation Title | Organisational Role | Mental Health Responsibility |
|---|---|---|---|
| NSW Health Organisations | Ministry of Health | • Primarily responsible for the public health system in New South Wales, particularly through public hospitals as well as associated agencies.<br>• Supports the executive and statutory roles of the Minister for Health, the Minister for Medical Research, and the Minister for Mental Health.<br>• Monitors the performance of state wide and specialist, health service organisations that make up NSW Health. | • As the system manager for mental health across NSW, the Ministry of Health is responsible for developing, managing and coordinating policy, strategy and program funding relating to mental health.<br>• The Mental Health Branch supports the delivery of mental health reforms across the state.<br>• The Health System Information and Performance Reporting (HSIPR) Branch of the Ministry provides mental health information and data to inform purchasing and performance management and drive improvements across the NSW system. |
| | Agency for Clinical Innovation (ACI) | • The Agency for Clinical Innovation works with clinicians, consumers and managers to design and promote better healthcare for NSW.<br>• ACI contributes to NSW Health strategic priorities through driving the development and implementation of evidence based innovations and promoting best practice to lead system improvements. | • The ACI Mental Health Network works collaboratively with clinicians, consumers and carers, hospitals, community managed organisations, and other key partners in the development and implementation of evidence-based programs, frameworks and models of care.<br>• The ACI offers the Network support and expertise in service redesign and evaluation, implementation, and healthcare innovation, in the development of evidence based initiatives, knowledge sharing and capability |

| Organisational Type | Organisation Title | Organisational Role | Mental Health Responsibility |
|---|---|---|---|
| | | | building. |
| | Bureau for Health Information (BHI) | • The Bureau for Health Information is responsible for delivering independent, accurate and comparable information on the performance of the public health system in New South Wales in ways that enhance the system's accountability and inform efforts to improve healthcare.<br>• Alongside the System Information and Analytics Branch (SIA) of the Ministry, the BHI disseminates information to inform system performance and drive reform. | • The BHI will issue a *Data Matters* report in 2018 to scope and discuss plans for measuring and publicly reporting on the performance of public mental health services. In 2019, BHI expects to issues a thematic *Insights* report, comprising comparative analysis of performance against a set of agreed indicators<br>• Mental health reporting undertaken by BHI also includes:<br>o Reporting in its annual report *Healthcare in Focus* on selected indicators with state and LHD-level comparisons (Seclusion events in psychiatric acute inpatient unit; follow-up in the community within seven days of discharge; and readmission within 28 days of discharge).<br>o In 2013, BHI produced *Patient* |

| Organisational Type | Organisation Title | Organisational Role | Mental Health Responsibility |
|---|---|---|---|
| | | | *Perspectives: Mental health services in NSW public facilities*, which drew on the self-reported experiences of approximately 5,000 mental health patients. |
| | Clinical Excellence Commission (CEC) | • The Clinical Excellence Commission promotes and supports improved clinical care, safety and quality across the NSW public health system.<br>• CEC contributes to the NSW Health strategic priority of providing world-class clinical care by continuing to embed quality improvement to ensure safer patient care. | • The Mental Health Drug and Alcohol Root Cause Analysis (RCA) Review Committee meets to review investigation findings, classify and theme system issues and escalate issues of concern to the local health districts and to the Clinical Risk Action Group, the peak quality and safety group within NSW Health.<br>• This process aims to inform opportunities for system-related improvement through the identification of key issues, creating context and providing greater insight into mental health incidents. |

| Organisational Type | Organisation Title | Organisational Role | Mental Health Responsibility |
|---|---|---|---|
| | Health Education and Training Institute (HETI) | • The Health Education and Training Institute supports education and training of the NSW Health workforce that:<br>o supports safe, high quality, multidisciplinary, team-based, patient-centred care<br>o meets service delivery needs and operational requirements; and<br>o enhances workforce skills, flexibility and productivity.<br>• HETI supports the NSW Health strategic priority of supporting its people and culture by developing effective health professional managers and leaders and through other capacity building activities. | HETI's Mental Health Portfolio provides mental health education and training for the mental health workforce, the wider health workforce on mental health related matters and works with sector partners for improved mental health and wellbeing. Education and training is provided across a continuum of activities including short courses through to higher education awards. |
| | Local Health Districts (LHDs) | • Local Health Districts are responsible for providing health services in a wide range of settings, from primary care posts in the remote outback to metropolitan tertiary health centres (eight local health districts cover the greater Sydney metropolitan regions, and seven cover rural and regional NSW). | • LHDs provide comprehensive and specialist mental health services to consumers and carers, as well as providing training, education, research and evaluation programs.<br>• These services include inpatient and community mental health care, from prevention and early intervention to treatment, rehabilitation and continuing care. |

| Organisational Type | Organisation Title | Organisational Role | Mental Health Responsibility |
|---|---|---|---|
| | Justice Health & Forensic Mental Health Network | Justice Health and Forensic Mental Health Network is a state-wide Board-governed Specialty Network delivering health care to adults and young people in contact with the forensic mental health and criminal justice systems, across community, inpatient and custodial settings. | • The Justice Health & Forensic Mental Health Network provides comprehensive health services to people in the adult correctional environment, to those in courts and police cells, to juvenile detainees and to those within the NSW forensic mental health system and in the community.<br>• The Network's Forensic Hospital caters for correctional patients as defined by the *Mental Health (Forensic Provisions) Act 1990*. |
| NSW Government Agencies and Organisations | NSW Government Agencies:<br>• Department of Family and Community Services<br>• Department of Education<br>• Department of Justice<br>• Department of Premier and Cabinet<br>• Audit Office of NSW | The NSW Government agencies listed provide a range of programs, services, support and audit functions, aligned to their respective portfolio responsibilities. | The availability of agency and community network support services such as community services and housing, education and justice are critical in ensuring people who experience mental illness have access to a sustainable continuum of care. (Refer to Chapter Two: Other NSW Government Agencies for further detail). |
| | Mental Health Review Tribunal | The Mental Health Review Tribunal is a specialist quasi-judicial body established under the *Mental Health Act 2007*. | • The Mental Health Review Tribunal has a wide range of powers that enable it to make and review orders and to hear some appeals about the treatment and care of people with a mental illness.<br>• The Tribunal reviews both voluntary and involuntary patients in civil hearings, and reviews the cases of all forensic patients who have been found not guilty by reason of mental illness, who have been found unfit to be tried or who have been transferred from prison to hospital because of a mental illness. |

| Organisational Type | Organisation Title | Organisational Role | Mental Health Responsibility |
|---|---|---|---|
| | Mental Health Commission of NSW | • The Mental Health Commission of NSW was established for the purpose of monitoring, reviewing and improving mental health and wellbeing for people in NSW.<br>• The Commission is an independent statutory body which helps drive reform that benefits people who experience mental illness and their families and carers. | The *Mental Health Commission Act 2012* outlines the Commission's functions. |
| National Government Organisations | National Mental Health Commission (NMHC) | The National Mental Health Commission is an Australian government executive agency established to provide independent reports to community and government on mental health services and outcomes. | The NMHC supports the Australian Government to deliver an efficient, integrated and sustainable mental health system to improve mental health outcomes for Australians and help prevent suicide, and provide independent reports and advice to the community and government on the effectiveness of the mental health sector. |
| | National Disability Insurance Agency (NDIA) | The National Disability Insurance Agency (NDIA) is an independent statutory agency whose role is to implement the National Disability Insurance Scheme (NDIS), developed to support individuals with a significant and permanent disability, and their families and carers. | The NDIS will introduce a financial support system to enable eligible people with a psychiatric disability to access a wide range of support services to facilitate their participation in community life. |
| | Australian Institute of Health and Welfare (AIHW) | The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act to provide reliable, regular and relevant information and statistics on Australia's health and welfare. | The AIHW collects and reports information on a wide range of aspects relating to mental health and mental health service providers and support services. |

| Organisational Type | Organisation Title | Organisational Role | Mental Health Responsibility |
|---|---|---|---|
| | Primary Health Networks (PHNs) | Primary Health Networks (PHNs) were established with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care. | • PHNs have responsibility for planning and integrating mental health at the regional level across Australia.<br>• Commonwealth mental health program funding was transitioned to PHNs in 2016 to form a newly created mental health flexibly funding pool. |
| Community Managed Organisations (CMOs) (Funded by NSW Mental Health Commission) | Being \| Mental Health and Wellbeing Consumer Advisory Group | Being \| Mental Health and Wellbeing Consumer Advisory Group is the independent peak body for people with lived experience of mental health issues (consumers). Being works with consumers to ensure the lived experience voice is captured and at the forefront of influencing change in legislations, policy and service delivery. | Being undertakes advocacy, policy, training, research, and organisational and governance development activities on key consumer issues. Being runs community awareness events and forums with the goal of improving the wellbeing, lives and experiences of all people with a lived experience of mental illness. |
| | Mental Health Carers NSW | Mental Health Carers NSW (formerly ARAFMI) is the NSW peak body for mental health carers. | Mental Health Carers NSW consult carers to gain insights into their experiences with the mental health system and their views about it, to provide feedback on policies and services to the Commission, government and service providers. |
| | WayAhead | WayAhead (formerly Mental Health Association NSW) promotes mental health and wellbeing through public education, support and advocacy. | WayAhead undertakes advocacy, education and support services to mental health consumers, their families and carers, and to the general public. |
| | beyondblue | beyondblue is an Australian, independent non-profit organisation working to address issues associated with depression, anxiety disorders and related mental disorders. | beyondblue works in partnership with health services, schools, workplaces, universities, media and community organisations, as well as people living with anxiety and depression, to raise community awareness of anxiety and depression and reduce associated stigma. |

| Organisational Type | Organisation Title | Organisational Role | Mental Health Responsibility |
|---|---|---|---|
| Other CMOs/Non-Government Organisations and Affiliated Health Organisations — National | • Mental Health Australia (MHA)<br>• The Black Dog Institute<br>• Mind Australia<br>• SANE Australia<br>• Headspace<br>• Lifeline | Non-government organisations at the state and national level provide a range of programs, initiatives and support services to people with mental illness, their families and carers.<br><br>*Please note the organisations and services listed are indicative only. | Non-government organisations at the state and national level provide a range of programs, initiatives and support services to people with mental illness, their families and carers. |
| Other CMOs/Non-Government Organisations and Affiliated Health Organisations — NSW | • Aftercare Association<br>• Mental Health Association NSW<br>• Mental Health Coordinating Council (MHCC)<br>• Richmond Fellowship of NSW<br>• Transcultural Mental Health Centre (TMHC)<br>• CAN Mental Health<br>• Centre for Rural and Remote Mental Health (CRRMH)<br>• Schizophrenia Fellowship of NSW | | |

# APPENDIX 8
# COMPARISON OF MENTAL HEALTH COMMISSIONS ACROSS JURISDICTIONS

# APPENDIX 8: COMPARISON OF MENTAL HEALTH COMMISSIONS ACROSS JURISDICTIONS

| Organisation/ Jurisdiction | Establishment | Number of Commissioners | Budget | Full time employees (at June 2017) | Functions | Principles | Governance/Reporting Arrangements |
|---|---|---|---|---|---|---|---|
| Mental Health Commission of NSW | Established in 2012 under the *Mental Health Commission Act 2012 (NSW)* | One Commissioner, five Deputy Commissioners | $10.55M (2016/17) | 22 | (a) Prepare a draft strategic plan for the mental health system in NSW<br>(b) Monitor and report on the implementation of the strategic plan<br>(c) Review and evaluate, and report and advise on, mental health services and other services and programs provided to people who have a mental illness, and other issues affecting people who have a mental illness<br>(d) Promote and facilitate the sharing of knowledge and ideas about mental health issues<br>(e) Undertake and commission research, innovation and policy development in relation to mental health issues<br>(f) Advocate for and promote the prevention of mental illness and early intervention strategies for mental health<br>(g) Advocate for and promote the general health and well-being of people who have a mental health illness and their families and carers<br>(h) Educate the community about mental health issues. | The following principles are to govern the work of the Commission:<br>(a) people who have a mental illness, wherever they live, should have access to the best possible mental health care and support.<br>(b) people who have a mental illness and their families and carers should be treated with respect and dignity.<br>(c) the primary objective of the mental health system should be to support people who have a mental illness to participate fully in community life and lead meaningful lives.<br>(d) the promotion of good mental health and the effective provision of mental health services are the shared responsibility of the government and non-government sectors.<br>(e) an effective mental health system requires:<br>(i) a co-ordinated and integrated approach across all levels of government and the non-government sector, including in the areas of health, housing, employment, education and justice, and<br>(ii) communication and collaboration between people who have a mental illness and their families and carers, providers of mental health services and the whole community. | Minister for Health and Minister for Mental Health conjointly responsible. |

| Organisation/ Jurisdiction | Establishment | Number of Commissioners | Budget | Full time employees (at June 2017) | Functions | Principles | Governance/Reporting Arrangements |
|---|---|---|---|---|---|---|---|
| Queensland Mental Health Commission | Established in 2013 under the *Queensland Mental Health Commission Act 2013*. | One Commissioner | $8.7M (2016/17) | 18 | (a) Prepare a whole-of-government strategic plan<br>(b) Monitor and report to the Minister on implementation of the whole-of-government strategic plan<br>(c) Review the whole-of-government strategic plan<br>(d) Review, evaluate, report and advise on—<br>(i) the mental health and substance misuse system; and<br>(ii) other issues affecting relevant persons; and<br>(iii) issues affecting community mental health and substance misuse;<br>(e) Promote and facilitate the sharing of knowledge and ideas about mental health and substance misuse issues<br>(f) Undertake and commission research in relation to mental health and substance misuse issues<br>(g) Support and promote strategies that—<br>(i) prevent mental illness and substance misuse; and<br>(ii) facilitate early intervention for mental illness and substance abuse;<br>(h) 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<br>(i) to support and promote social inclusion and recovery of people with a mental illness or who misuse substances<br>(j) Promote community | (a) people with a mental illness or who misuse substances should:<br>• have access to quality mental health or substance<br>• misuse services, care and support, wherever they live<br>• be treated with respect and dignity<br>• be supported to participate fully in community life and lead meaningful lives<br>• have the same right to privacy as other members of society.<br>(b) Aboriginal and Torres Strait Islander peoples should be provided with treatment, care and support in a way that recognises and is consistent with Aboriginal tradition or Islander custom and is culturally appropriate and respectful.<br>(c) carers, family members and support persons for people with a mental illness or who misuse substances are:<br>• integral to wellbeing, treatment and recovery<br>• respected, valued and supported<br>–engaged, wherever possible, in treatment plans.<br>(d) an effective mental health and substance misuse system is the shared responsibility of the government, non-government and private sectors and requires:<br>• a coordinated and integrated approach, across all areas of health, housing, employment, education, justice and policing<br>• a commitment to communication and collaboration across public sector and publicly funded agencies, consumers and the community strategies that foster inclusive, safer and | Reports to the Queensland Minister for Health. |

| Organisation/ Jurisdiction | Establishment | Number of Commissioners | Budget | Full time employees (at June 2017) | Functions | Principles | Governance/Reporting Arrangements |
|---|---|---|---|---|---|---|---|
| | | | | | awareness and understanding about mental health and substance misuse issues, including for the purpose of reducing stigma and discrimination<br>(k) Take other action the commission considers appropriate to address the needs of relevant persons. | healthier families, workplaces and communities. | |
| Mental Health Complaints Commissioner – Victoria | Established in 2014 under the *Mental Health Act 2014 (Victoria)* | One Commissioner | $3M (2016/17) | 17 | (a) accept, assess, manage and investigate complaints relating to public mental health services<br>(b) endeavour to resolve complaints in a timely manner using formal and informal dispute resolution (including conciliation), as appropriate<br>(c) provide advice on any matter relating to a complaint<br>(d) make the procedure for making complaints in relation to services available and accessible, including publishing material about the complaint procedure<br>(e) provide information, education and advice to services about their responsibilities in managing complaints<br>(f) assist consumers and people acting on behalf of, or who have a genuine interest in the wellbeing of, consumers to resolve complaints directly with the service, either before or after the Commissioner accepts the complaint<br>(g) assist services in improving policies and procedures for resolving complaints | (a) People receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred.<br>(b) People receiving mental health services should be provided those services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life.<br>(c) People receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected.<br>(d) People receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk. (e) People receiving mental health services should have their rights, dignity and autonomy respected and promoted.<br>(f) People receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to. | Reports to the Victorian Minister for Mental Health. |

| Organisation/ Jurisdiction | Establishment | Number of Commissioners | Budget | Full time employees (at June 2017) | Functions | Principles | Governance/Reporting Arrangements |
|---|---|---|---|---|---|---|---|
| | | | | | (h) identify, analyse and review quality, safety and other issues arising from complaints and make recommendations for improvements to services, the Chief Psychiatrist, the Secretary and the Minister<br>(i) investigate and report on any matter relating to services at the request of the Minister. | (g) People receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to.<br>(h) Aboriginal people receiving mental health services should have their distinct culture and identity recognised and responded to.<br>(i) Children and young people receiving mental health services should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults, whenever this is possible.<br>(j) Children, young people and other dependents of people receiving mental health services should have their needs, wellbeing and safety recognised and protected.<br>(k) Carers (including children) for people receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible.<br>(l) Carers (including children) for people receiving mental health services should have their role recognised, respected and supported. | |

| Organisation/ Jurisdiction | Establishment | Number of Commissioners | Budget | Full time employees (at June 2017) | Functions | Principles | Governance/Reporting Arrangements |
|---|---|---|---|---|---|---|---|
| South Australia Mental Health Commission | Established 2015 under the *SA Public Sector Act 2009* | One Commissioner | $2.55M (2016/17) | 11 | (a) lead the development and subsequent implementation of South Australia's strategic mental health plan for 2017-2022.<br>(b) engage with the mental health sector and community to promote the mental health and wellbeing of South Australians.<br>(c) promote and facilitate the sharing of knowledge about mental health and wellbeing issues.<br>(d) develop policy proposals that from time to time may be requested by the Minister for Mental Health and Substance Abuse.<br>(e) undertake projects relating to the State's mental health and wellbeing as may from time to time be requested by the Minister for Mental Health and Substance Abuse.<br>(f) perform other functions relating to the mental health and wellbeing of South Australians as may be prescribed by Regulation. | Not specified. | Reports to the South Australian Minister for Mental Health and Substance Abuse. |

| Organisation/ Jurisdiction | Establishment | Number of Commissioners | Budget | Full time employees (at June 2017) | Functions | Principles | Governance/Reporting Arrangements |
|---|---|---|---|---|---|---|---|
| Western Australia Mental Health Commission | Established in 2010 under section 35 of the Public Sector Management Act 1994. | One Commissioner and three Assistant Commissioners | $963.1M (2016/017) | 303 | The Commission is responsible for planning and purchasing mental health, alcohol and other drug services in Western Australia (WA).<br>(NB - the Commission does not provide direct mental health services, these are provided through the WA Department of Health).<br><br>On 1 July 2015, the Commission amalgamated with the Drug and Alcohol Officer to deliver an integrated approach to helping people with mental health, drug and alcohol problems. | The principles and strategic direction of the Commission are guided by the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives.*<br><br>The Plan provides a roadmap for service development, transformation and expansion of mental health, alcohol and other drug services over the next ten years. | Reports to the Western Australian Minister for Mental Health. |

| Organisation/ Jurisdiction | Establishment | Number of Commissioners | Budget | Full time employees (at June 2017) | Functions | Principles | Governance/Reporting Arrangements |
|---|---|---|---|---|---|---|---|
| National Mental Health Commission | Established in 2012 as an independent executive government agency under the *Public Service Act 1999*. | Six Commissioners, one CEO and one Advisory Board Chair. | $2.76M (2016/2017) | 12 | (a) Deliver the Annual National Report Card;<br>(b) Develop data and reports with a particular focus on ensuring a cross sectoral perspective is taken<br>(c) Provide mental health policy advice to the Australian Government;<br>(d) Engage consumers and carers;<br>(e) Build relationships with stakeholders including service providers, government agencies, researchers, academics, and State and Territory Governments<br>(f) Undertake other relevant tasks as the responsible Minister may require from time to time<br>(g) Conduct data collection and cross-border monitoring of activity arising from the Fifth National Mental Health Plan;<br>(h) Expand the focus on consumer engagement to include development of a consumer and carer participation framework<br>(i) Strengthen its role supporting collaboration and translation of research into policy and practice;<br>(j) Provide evidence on specific issues which require cross-sectoral or cross-agency input; and<br>(k) Provide the advisory functions of the Australian Suicide Prevention Advisory Council. | Refer to National Mental Health Commission – Operating Principles (revised 2014) | The Commission reports directly to the Federal Minister for Health. |

| Organisation/ Jurisdiction | Establishment | Number of Commissioners | Budget | Full time employees (at June 2017) | Functions | Principles | Governance/Reporting Arrangements |
|---|---|---|---|---|---|---|---|
| New Zealand Health and Disability Commissioner | Mental Health Commissioner position was re-established in 2016 and is appointed under the *Health and Disability Commissioner Act 1994* | One Commissioner specifically for mental health within the organisation | $1M - budget for mental health and addiction section | 4 staff in mental health and addiction section (13 across total organisation) | (a) to make decisions on complaints, including complaints about mental health and addiction services, and<br>(b) to monitor and advocate for improvements to mental health and addiction services. | (a) advocating for a more inclusive society that supports the mental health and wellbeing of everyone<br>(b) engaging consumers/tangata whaiora, their families and whanau in service development and delivery<br>(c) creating a truly consumer-led healthcare<br>System. | Reports to the Federal Minister for Health. |
| Mental Health Commission of Canada | Established in 2007 in response to senate committee recommendation | No Commissioner position. The organisation is governed by a board of directors, assisted by an advisory council. | $15.2M (2016/2017) | Not specified. | (a) To develop a national mental health strategy (until 2008, Canada was the only G8 nation that did not have one).<br>(b) To oversee the development and implementation of an anti-stigma and anti-discrimination campaign.<br>(c) To create a Knowledge Exchange Centre, with the aim of mobilizing evidence-based knowledge to improve best practices and increasing dialogue across Canada. | (a) Champion ambitious, courageous, and progressive ideas<br>(b) Embrace the principles of recovery<br>(c) Be co-creators and collaborators<br>(d) Integrate the voices of people with lived experience, families, and caregivers into all of the work we do<br>(e) Promote and celebrate equity, diversity, and inclusion<br>(f) Encourage and develop leaders<br>(g) Seek and share new approaches in the spirit of continuous improvement<br>(h) Be passionate in our work,<br>(i) Celebrate the contributions of others. | Reports to the Canada Health, Government of Canada. |

| Organisation/ Jurisdiction | Establishment | Number of Commissioners | Budget | Full time employees (at June 2017) | Functions | Principles | Governance/Reporting Arrangements |
|---|---|---|---|---|---|---|---|
| Mental Health Commission (Ireland) | Established in 2002 under the *Mental Health Act 2001* | 13 Commission members including one Chair | €13.25M (2016/17) | 35.4 | (a) Appointing persons to mental health tribunals to review the detention of involuntary patients and appointing a legal representative for each patient;<br>(b) Establishing and maintaining a Register of Approved Centres i.e. we register inpatient facilities providing care and treatment for people with a mental illness and mental disorder.<br>(c) Making Rules regulating the use of specific treatments and interventions such as ECT (Electroconvulsive Therapy), seclusion and mechanical restraint;<br>(d) Developing Codes of Practice to guide those working in the mental health services and enable them to provide high quality care and treatment to service users.<br>(e) Appointing the Inspector of Mental Health Services who annually inspects mental health services. | MHC is focused on promoting the provision of the best possible standard of care for users of mental health services. A core element of this is the involvement of service users in all aspects of their care. The MHC is committed to the ongoing consultation of service users, their families, and their carers to obtain their views on mental health services in Ireland, and how they can be improved. | Reports to the Department of Health |
| Mental Welfare Commission for Scotland | Established in 1960 (legislation now inactive). Accords with the *Mental Welfare (Care and Treatment) Act 2003* | No Commissioner. | £4.45M (2016/17) | 79 | (a) duties to monitor the operation of the Act and to promote best practice<br>(b) specific powers and duties in relation to carrying out visits to patients, investigations, interviews and medical examinations, and to inspect records<br>(c) powers and duties to publish information and guidance, and to give advice or bring matters to the attention of others in the mental health law system. | Not specified. | Reports to the Scottish Government Health and Social Care Directorates. |

# APPENDIX 9
# RESEARCH PAPERS COMMISSIONED BY THE COMMISSION

# APPENDIX 9: RESEARCH PAPERS COMMISSIONED BY THE COMMISSION

More than 20 research papers were commissioned to support development of the Strategic Plan and the One Year On report. These are listed below:

## Papers in support of Living Well

- Australia's international human rights obligations
- Broke systems: breaking people: A report on carer expectations of the NSW draft Strategic Plan for Mental Health
- Building Community Resilience and Wellbeing Report
- Carers and Community Needs
- Clinical services planning for adults with intellectual disability and co-occurring mental disorders
- Culturally and linguistically diverse (CALD) Research to assist with development of draft Strategic Plan
- Leaders Forum on Mental Health and CALD Communities
- Mental health and substance use: opportunities for innovative prevention and treatment
- NSW mental health services in context
- Primary Care Mental Health Strategy
- Strategies for adopting and strengthening e-mental health
- Telling it like it is: Community Report
- Towards a Mental Health Strategy for NSW: Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) Community Consultations
- Trauma-informed care and practice: Forum report and evaluation
- Views of the NSW Refugee Health Improvement Network
- A rapid review of the evidence on the costs and impacts on the economy and productivity due to mental ill health
- A rapid review of economic modelling of the costs and benefits of interventions in the areas of mental health.

## Papers in support of One Year On

- Government agencies advice to the Commission on progress
- The Work of the Mental Health Reform Implementation Taskforce
- Baseline analysis of the 10 Living Well indicators
- Findings of the Commission's Ready for Change community survey
- Examples of Reform Initiatives and Innovative Practice across NSW
- An overview of policy changes affecting mental health since the launch of Living Well in December 2014.

# APPENDIX 10
# REPORTS PUBLISHED BY THE COMMISSION

# APPENDIX 10: REPORTS PUBLISHED BY THE COMMISSION

A selection of reports published by the Commission during the five-year review period is listed below:

- Living Well in our Community – Paper 1 (2013)
- Mental Health and Homelessness: Final Report (2013)
- Review NSW Institute of Psychiatry (2013)*
- Living Well: Putting people at the centre of mental health reform in NSW: A Report* (2014)
- Promotion, Prevention and Early Intervention: An Evidence Guide (2014)
- Support in Tough Times (2014)
- Proposed Suicide Prevention Framework for NSW (2015)
- Medication and Mental Illness: Perspectives (2015)
- The NSW NDIS and Mental Health Analysis Partnership Project (2015)
- Community Visits Report (2015 and 2016)
- One Year On: Progress Report on the implementation of Living Well: A Strategic Plan for Mental Health in NSW 2014-2024 (2016)
- Physical Health and Mental Wellbeing: An Evidence Guide (2016)
- The Effectiveness of Services Led or Run by Consumers in Mental Health: a rapid review of evidence for recovery-oriented outcomes (2016)
- Mental Health and Wellbeing Strategy for First Responder Organisations in NSW (2016)
- Towards a just system: Mental illness and cognitive impairment in the criminal justice system: directions for action (2017)*
- Review of transparency and accountability of mental health funding to health services (2017)*
- Living Well in Later Life: The Case for Change (2017)
- Living Well in Later Life: A Statement of Principles (2017)
- Living Well: Community Perspectives of Change (2017)
- Health Justice Partnerships in NSW: Position Paper (2017)
- Stigma and Discrimination in NSW (2017)

* reports marked with an asterisk were tabled in Parliament

Note: some reports have been co-authored by the Commission with other organisations.

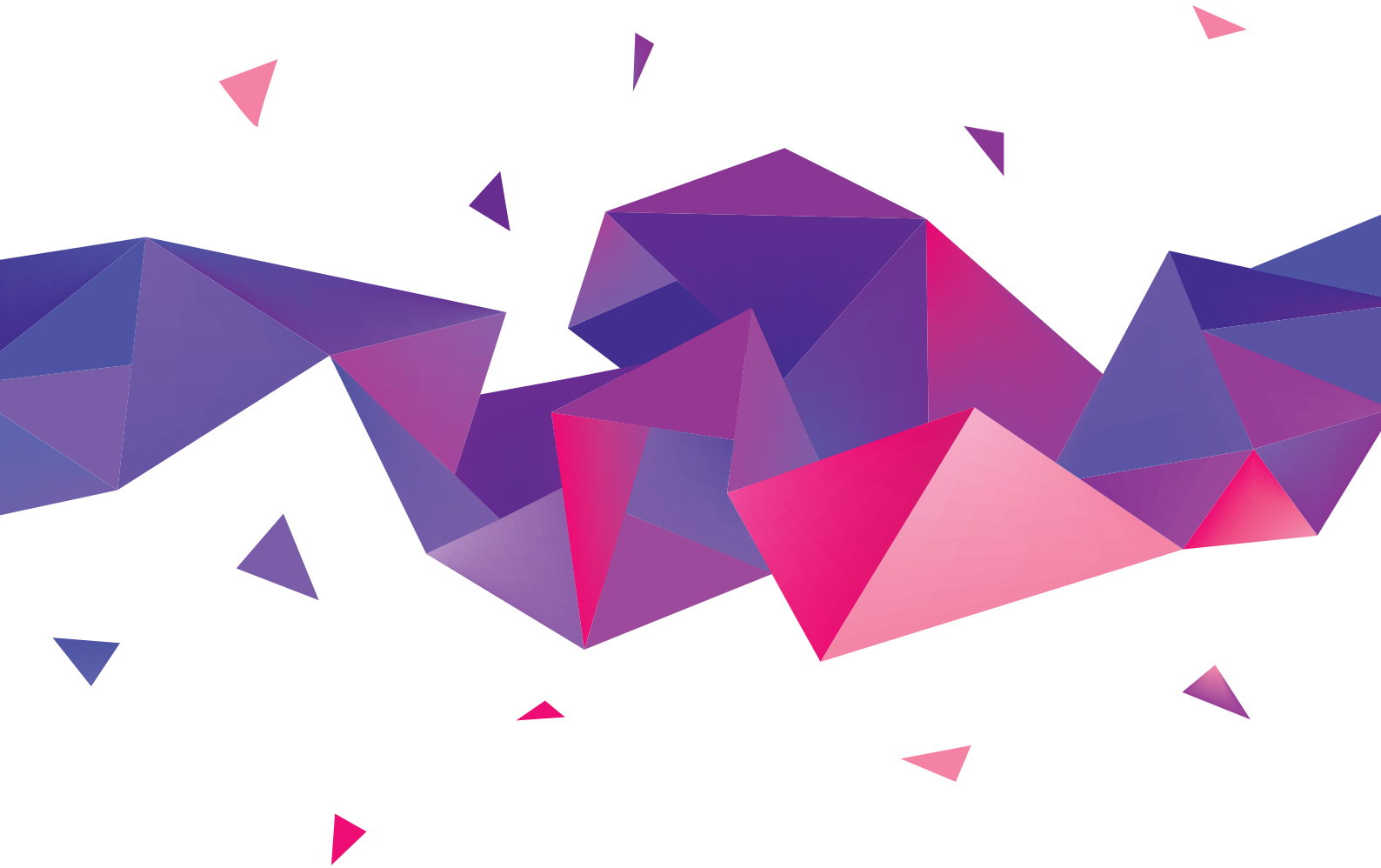
# APPENDIX 11
# SUBMISSIONS MADE BY THE COMMISSION

# APPENDIX 11: SUBMISSIONS MADE BY THE COMMISSION

The Commission has made more than 20 submissions to inquiries and legislative reviews between 2012 and 2017. Submissions are made as part of the Commission's advocacy function and have contributed to the expert advice available to policy-makers in relation to mental health and wellbeing in NSW. The submissions are listed below:

- Review of the *Mental Health Act 2009* (2013)
- Mental health recovery and social housing (2015)
- Indefinite detention of people with cognitive and psychiatric impairment in Australia (2016)
- Redesign of University of Sydney Medical School curriculum (2016)
- Art and mental health (2016)
- Foundations for Change: Homelessness in NSW (2016)
- NSW Youth Health Policy Consultation (2016)
- Family and Community Services Targeted Early Intervention Program Reform (2016)
- NSW Health, Draft NSW Perinatal Mental Health Mother-Baby Unit Model of Care (2016)
- Draft Fifth National Mental Health Plan (2016)
- Disability employment services (2017)
- City of Sydney Disability Inclusion Action Plan 2017-2021 (2017)
- Delivery of outcomes under National Disability Strategy 2010-2020 (2017)
- Provision of services under NDIS (2017)
- Review of the *Guardianship Act* 1987 (2017)
- Review of the *Coroners Act* (in confidence) (2017)
- Social Services Legislation Bill (2017)
- NSW Treasury, draft Internal Audit and Risk Management Policy
- Commonwealth Department of Health, Issues Paper on Clozapine
- A response to the National Safety and Quality Health Standards Review: Standard MS: Medication safety
- Submission to the Royal Commission on Child Sexual Abuse

# APPENDIX 12
# EXAMPLES OF FORUMS AND EVENTS HELD BY THE COMMISSION



# APPENDIX 12: EXAMPLES OF FORUMS AND EVENTS HELD BY THE COMMISSION

As part of the function of sharing knowledge about mental health and wellbeing, and engaging with consumers, carers and the community, the Commission regularly holds forums and events. Examples of forums and events held by the Commission include:

- The contribution to mental Health reform by people who have experienced mental health challenges, Prof. Larry Davidson, public lecture and leaders' forum (2013)
- Recovery into Practice forum (2013)
- Mental Health Review Tribunal Recovery forum (2013)
- Trauma Informed Care and Practice forum and workshop (2013)
- Building the Community Sector forum (2014)
- Minding Our Mental Health Youth Week forum (2014)
- Facilitating Communication in the Criminal Justice System forum (2015)
- Open Dialogue public information session, Dr Christopher Gordon and Brenda Miele Soares (2015)
- Wraparound Milwaukee presentation, Bruce Kamradt (2015)
- International Wellbeing Indicators workshop (2015)
- Health Justice Partnerships workshop (2015)
- Consumer Led Research Network public forum (2015)
- Peer Work forum (2015)
- No offence…, comedy night (2015)
- Slow Psychiatry, Dr Sandra Steingard, public lecture (2016)
- Living Well @ Work community forum (2016)
- Promoting Mentally Healthy Cities, Dr Arthur Evans, public lecture (2016)
- Parliamentary Friends of Mental Health showcase and forums (2016)
- Check Up from the Neck Up community events (2016 and 2017)
- Growing Up Digital public forum (2017).

In addition, as part of the development of the Strategic Plan and *Living Well: A Report*, forums were held including with communities in Broken Hill, Kempsey, Tamworth, Nowra and Dubbo.

Note: some events were co-hosted by the Commission with other organisations.

# APPENDIX 13
# PRIORITIES OF THE COMMISSION IN THE 2016 MINISTERIAL CHARTER LETTER

# APPENDIX 13: PRIORITIES OF THE COMMISSION IN THE 2016 MINISTERIAL CHARTER LETTER

## Undertake regular NSW mental health community forums

As part of its mission to improve mental health and wellbeing for all people in NSW, the Commission conducts visits to communities throughout the State. These visits are intended to enhance the Commission's understanding of any barriers to wider implementation of community-based support. They are also an opportunity to identify and highlight programs and projects that successfully embody community-based support and recovery values, which may serve as models for reform in other regions.

In 2016 and 2017 community visits were made to metropolitan, rural and regional communities in NSW:, Central Coast, Clarence Valley, Grafton, Nepean Blue Mountains, Newcastle, Orange, Port Stephens, South Western Sydney and Western Sydney.

Since 2013, the Commission met with over 3,000 people during the visits, including over 200 personnel from NSW Government agencies. More than 20 forums and information sessions were held across NSW. Reports have been produced for each visit and sent to stakeholders. There have been over 100 views of the 11 Community Visits videos on the Commission's website.

In addition to community visits, the Commission has held more than 20 forums to lead community discussion of issues affecting mental health consumers, and their carers and families.

## Collaboration to ensure the National Disability Insurance Scheme (NDIS) meets the community's needs

The Commission has engaged extensively in the development and rollout of the NDIS to ensure that it meets the needs of mental health consumers with a psychosocial disability. A Community of Practice was established in the Hunter region to provide a forum for community managed organisations, consumers, carers and government agencies to collaborate for better outcomes.

As the NDIS rollout extends into 2017 and beyond, the Commission continues to have a key role in advocating for appropriate support for people with psychosocial disability to be implemented as part of the NDIS.

The Commission has hosted a number of forums relating to the NDIS, and developed a video resource *NDIS – mental health perspectives*, which shows the experiences of two participants in the NDIS.

The Commission has provided expert advice on the NDIS Quality and Safeguarding Framework. The Commission has also contributed through membership of the NDIA Mental Health Sector Reference Group, and made a submission to the Commonwealth Joint Standing Committee on the NSW.

## Promoting and developing the mental health peer workforce

The Peer Work Hub, launched in May 2016, is a significant achievement of the Commission. The Peer Work Hub is an online resource supporting employers to establish a peer workforce, including a business case, toolkit, language guides, and case studies. Supporting people with lived experience of mental illness to participate in the workforce helps people to contribute and lead fulfilling lives. Having people with experience of mental illness in the workforce also contributes to reducing stigma and discrimination against people with mental illness in all settings.

A key outcome of the Peer Work Hub is the establishment, by the Ministry of Health, of a state-wide coordinator position for peer work and the inclusion of performance indicators relating to the peer workforce in funding agreements with Local Health Districts.

*'Employing people with lived experience of mental illness in peer worker roles brings a tremendous range of benefits, including providing hope and evidence of recovery for people experiencing mental health issues. Yet while peer workers have been employed in the public mental health sector for 20 years, they have not always been welcomed or accepted and their numbers remain low within many services. NSW needs formal resources and policies that demonstrate the value of establishing and growing a peer workforce, and how to go about it'*

Commission website, Achievements page

## Collaboration with the Parliamentary Friendship Group

Since 2016 the Parliamentary Friends of Mental Health Group has endeavoured to raise awareness and understanding of mental health issues and experiences. The Group supports community events and provides a forum for discussion of mental health in the NSW Parliament. The Mental Health Commissioner is an associate member of the Parliamentary Friendship Group.

In 2016 a Parliamentary Showcase was held to promote the work of community-based organisations among Members of Parliament and their staff. Around 20 organisations showcased their work.

## Addressing the mental health needs of young people

The Growing Up Digital public forum was held in 2017 in Sydney with over 160 participants, to discuss supporting the mental health of young people in an 'always on' digital world.

**Using technology to support mental health among young people**

The Commission partnered with the **Young and Well Cooperative Research Centre** and the **Brain and Mind Centre** to trial an innovative system of apps and e-tools to help young people improve their mental health and wellbeing. The NSW Synergy Online Ecosystem guides young people to tools supporting their individual mental health needs. It has been trialled in **Western Sydney, Central Coast and Far West** communities of young people in a participatory design and evaluation approach.

# Data availability and transparency

The Commission has made a substantial effort towards increasing the amount and quality of data available to government, service providers, consumers, carers and family members. Through strategic projects with the Australian Bureau of Statistics, universities and NSW Government agencies, new data-sets are being developed and analysed, and linked to existing data-sets. This has potential to produce important new insights that can guide service development and planning.

The Commission has created a suite of interactive presentations and snapshots, which make NSW mental health-related data more accessible to consumers, academics and the whole community. Topics currently available as snapshots or interactive guides include:

- Access to mental health services
- Disadvantage
- Patterns of treatment
- Psychological distress and health
- Suicide in NSW by Aboriginal status
- Suicide in NSW by age
- Usage of mental health services and medications in NSW.

*'By allowing users to dynamically create visual representations of data relationships, according to their particular interests, the Commission hopes to make a positive contribution to evidence-based policy development and public discussion'*

Commission website, Data and analysis page

Other data-related projects, discussed in this report, include:

- The Far West Mental Health Atlas
- A review of coronial data to explore causes of premature deaths among people living with mental illness
- Data linkage to better understand access to mental health services by people with intellectual disability.

# Facilitate knowledge exchange

The Ministerial Charter Letter requires the Commission to host the International Initiative for Mental Health Leadership in 2017. The Commission hosted the conference in Sydney on

March 2017, with over 400 participants from around the world attending for five days of information exchange. The Commission provided information about the conference on its website.

## Continual development of key reform committees

The Commission is responsible for two reform Committees:

- The Institute of Psychiatry's Transition Oversight Committee
- The Suicide Prevention Advisory Group.

With the transition of the Institute of Psychiatry to the Health Education and Training Institute in 2016, the Transition Oversight Committee has concluded.

In addition, the Mental Health Commission is on observer on the Mental Health Taskforce, for which the Mental Health Branch provides the secretariat. The Mental Health Taskforce and the Suicide Prevention Advisory Group continue to operate to guide reform of mental health systems in NSW.