Our Healthy Clarence

Evaluation Report

July 2018

Community Wellbeing Collaboratives

Prepared for Our Healthy Clarence Steering Committee

Centre for
**Rural & Remote
Mental Health**

About the CRRMH

The Centre for Rural and Remote Mental Health (CRRMH) is based in Orange NSW and is a major rural initiative of the University of Newcastle and the NSW Ministry of Health. Our staff are located across rural and remote NSW.

The Centre is committed to improving mental health and wellbeing in rural and remote communities. We focus on the following key areas:

- the promotion of good mental health and the prevention of mental illness;
- developing the mental health system to better meet the needs of people living in rural and remote regions; and
- understanding and responding to rural suicide.

As the Australian Collaborating Centre for the International Foundation for Integrated Care, we promote patient-centred rather than provider-focused care that integrates mental and physical health concerns.

As part of the University of Newcastle, all of our activities are underpinned by research evidence and evaluated to ensure appropriateness and effectiveness.

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Executive Summary – Our Healthy Clarence

After a series of community initiated forums, and community consultation in response to suicides, Our Healthy Clarence (OHC) was established in June 2016 to support the community of the Clarence Valley in their mental health and wellbeing. OHC is a coordinated response involving the community, health and community services, and other key agencies working collaboratively across the Clarence Valley to achieve improved community mental health and wellbeing.

We conducted interviews with 48 key stakeholders of OHC to identify the features of the initiative that contributed to its success and to guide recommendations for the future of the initiative.

Findings

It was acknowledged that whilst OHC is still in its infancy, there have been significant achievements to support community mental health and well-being in the Clarence Valley. There was a strong commitment that **mental health and wellbeing** are the foundation of OHC with its positive and proactive impact on the community. This commitment was driven by a mostly **common understanding of the purpose** of the initiative. Interviewees identified training and capacity building, school education, headspace, pop-up hubs, Clarence Youth Action, the Wayback service and community engagement and awareness building as some of the key initiatives OHC has enabled to work towards its objectives.

Key Achievements

- Increased **collaboration between services**, which had previously been perceived to work in isolation; this has improved outcomes for clients. Moreover, **access to services** had improved.
- **Postvention strategies** have been applied in schools and the broader community and have been a catalyst for the community moving to a sense of positivity.
- There was a perception the approach taken by **schools** was exemplary. This was viewed to be due to consistency between all schools, leadership and system level changes to support sustainability supported by a strong commitment to training.
- There was agreement that engagement with and participation of members of the **Aboriginal and Torres Strait Islander community** had worked well, but that efforts could be increased, particularly in areas outside of Grafton.
- The engagement of **young people**, supported by Clarence Youth Action, had been very effective.
- The **changes in media responses** to mental health and suicide was viewed as positive for the wellbeing of the community.
- According to the participants these successes were primarily to do with: **community commitment**, **leadership** and the position of the **OHC coordinator**.

Impact

Although it was recognised that the **OHC plan needs review** and that **promotion** was an ongoing process, there were a number of changes in the community that were identified by the stakeholders. These included a **change in the community narrative** about mental health and wellbeing, which promoted discussions about mental health and facilitated help seeking behaviour. There was also a perception that the Clarence Valley now has a sense of **optimism** across the community. It was recognised that this had been driven by **community solutions** and **collaboration**, which may contribute to further community development.

Our Key Recommendations

Focus on mental health and wellbeing

1. The focus on community mental health and wellbeing should be maintained
2. The lessons from OHC should be shared with other communities and contribute to the community wellbeing collaboratives

Planning

3. Informed by the community, develop a new plan to guide the efforts of OHC for the next 5 years focusing on building sustainability.
4. Review the objectives, with consideration given to those relevant for target groups and/or settings
5. Ensure the plan identifies key indicators related to the strategies and lead agencies responsible for delivery

Future strategies

6. Ensure multiple strategies are applied for each objective which are focused on individuals, the community and systems, and which build the capacity of the community and services
7. Continue to tailor strategies to specific target groups

Community engagement and communication

8. Finalise and implement the community engagement strategy ensuring
   a. broad engagement across the community
   b. tailored engagement strategies to hard-to-reach groups
   c. inclusion of feedback strategies on progress
9. Review the website in the context of the revised plan

Steering committee

10. On finalisation of the new OHC plan, the membership of the steering committee should be reviewed with consideration to:
    a. Ensuring balance between the number of community members and service representatives
    b. Community members being influencers in their communities and representing locations and/or specific target groups
    c. Time frames for appointment to and review by the steering committee
    d. Service representatives are decision makers
    e. Mechanisms are in place to manage attrition of members
11. The appointment of the chair should be based on their capacity to chair meetings and strategically negotiate and advocate to achieve the outcomes of the plan
12. The terms of reference require review in the context of the new plan and ensuring accountability between the steering committee and the working parties

Working parties

13. Develop terms of reference for the working parties with purpose and functions relevant to advice and delivery of the strategies in the plan
14. Membership of the working parties needs to reflect the objectives in the plan
15. The terms of reference need to ensure accountability between the working parties and the steering committee

Advisory group

16. The functions and role of the advisory group need to be made explicit with clear terms of reference, membership and relationship within overall governance

Ongoing evaluation

17. Maintain the commitment to evaluation of the OHC initiative
18. Ensure the results of the evaluation refine the initiative and are shared with other communities

Background

The Clarence Valley Local Government Area (LGA) is located in the Northern Rivers region of New South Wales and is bounded in the north by the areas of Kyogle Council and the Richmond Valley Council, Coffs Harbour City and Bellingen Shire in the south, and the Armidale Regional Council, the Glen Innes Severn Council and Tenterfield Shire in the west (Figure 1)[1].

Figure 1: Clarence Valley LGA
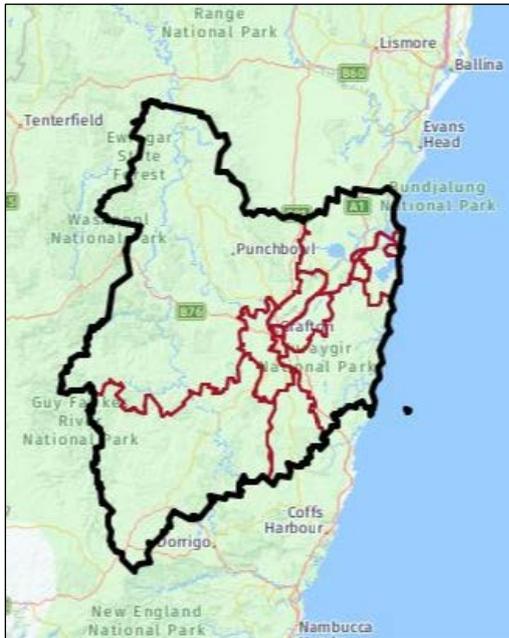
In 2017 the estimated resident population in the Clarence Valley LGA was 51,298. There is a higher proportion of Aboriginal and Torres Strait Islander peoples in the Clarence Valley (6.3%) compared to NSW (2.9%)[1]. Compared to New South Wales, the Clarence Valley has a lower proportion of people in the younger age groups (0 to 17 years) and a higher proportion of people in the older age groups (60+ years). Overall, 20.2% of the population was aged between 0 and 17, and 34.0% were aged 60 years and over, compared with 22.1% and 21.9% respectively for New South Wales[1].

Unemployment was higher in the Clarence Valley LGA (9%) in 2016 compared with NSW (6.3%)[1]. The relative level of socio-economic disadvantage is measured by the Socio-Economic Indexes for Areas (SEIFA), which is based on a range of census characteristics including low income, low educational attainment, high unemployment, and jobs in relatively unskilled occupations. It provides the relative level of disadvantage in one area compared to others. In 2016, the Clarence Valley SEIFA score was 923 placing this LGA in the second lowest quintile of disadvantage for LGAs in NSW[1].

There are a number of indicators which show that there is a significant burden of illness associated with mental illness and suicide in the Clarence Valley. For people aged 18 years and over, the estimates of those with high or very high psychological distress, based on the Kessler 10 Scale (K10) are higher in the Clarence Valley (12.5%) compared with NSW (11%)[2]. The estimates of people with mental and behavioural problems in 2011-2012 were higher in the Clarence Valley (16.2%) compared with NSW (13.1%)[2]. In contrast, the rate of hospitalisations for mental health-related conditions to public and private hospitals for people in the Clarence Valley was lower (1326/100,000 peoples) compared to the rate in NSW (1894/100,000 people)[2].

In the last decade, intentional self-harm hospitalisations for males and females have increased and are higher than the rates for NSW[3]. The average annual age-standardised rate of suicide in 2010-2014 was 10.8/100,000 people in the Clarence Valley compared to the rate in NSW of 9.4/100,000 people[2].

These indicators were reflected in concerns of the community about the levels of mental illness and suicide in the Clarence Valley. In addition, the community was concerned that access to treatment services and programs for mental health promotion, prevention and early intervention was inadequate. These views resulted in action by the community to address mental health and suicide across the community.

Aims and Methods

Aims

This project aimed to evaluate the process and progress of implementation of the Our Healthy Clarence (OHC) initiative. The results of this evaluation will inform the understanding of the Community Wellbeing Collaboratives being developed by the Centre for Rural and Remote Mental Health.

Methods

We interviewed 48 key stakeholders (18 years and over) involved with the OHC from the Clarence Valley LGA. Stakeholders included: consumers, carers and interested community members; service providers from mental health, drug and alcohol and other community support services; and representatives from other agencies such as Departments of Education and Police. Semi-structured interviews were conducted with these being audio-recorded and analysed for common themes.

For a full description of the methods see Appendix 1.

About this report

This report provides an overview of OHC and describes the key findings of the evaluation, discusses these findings and makes some broad recommendations related to the next steps of the OHC initiative. The results of the evaluation will be presented to the OHC Steering Committee for critical review and discussion of the next steps.

Overview of Our Healthy Clarence

Community forums and actions by concerned community members began in the second half of 2015 and initiated the need for a coordinated plan and response for mental health and wellbeing in the Clarence Valley. To that end, Our Healthy Clarence (OHC) was established in June 2016 and a plan was developed through community coproduction; the plan was launched by the Federal Minister for Health in February 2017. OHC is a coordinated response involving the community, health and community services, and other key agencies working collaboratively across the Clarence Valley to achieve improved community mental health and wellbeing. This initiative was established in response to a high number of suicides in the years leading up to its establishment.

There were four key steps in the establishment of OHC including:

- A number of community meetings to discuss the issue
- Community interviews undertaken by a consultant external to the Clarence Valley to identify risk and protective factors and existing mental health and wellbeing strategies
- A series of workshops to commence development of local strategies which were to form the basis of a plan
- The formation of the OHC Steering Committee to lead the development and implementation of the 2016 – 2018 plan aimed at improving mental health and wellbeing in the Clarence Valley

The plan was developed as a community initiative with no one organisation having jurisdiction over it and was informed by evidence for community wellbeing and suicide prevention initiatives.

Key findings from initial consultations

In March 2016, following community concerns regarding mental health and suicide in the Clarence Valley, a community committee, made up of community members and service representatives, was established. This committee authorised the conduct of consultations to explore community views about mental health and well-being to guide a community response to a number of suicides in the Clarence Valley in the previous 18 months.

The resultant report identified significant community concerns about mental health problems and suicide in the Clarence Valley. It also identified a range of factors associated with individuals and families, the community and structural issues associated mental illness and suicide

The findings of these consultations also identified that there was a diverse and disparate range of programs, services and initiatives already in place in the Clarence Valley, but a lack of awareness about these and limited coordination across services. As a result, there was commitment to address mental health and well-being with strong support for coordinating programs, services and initiatives under one banner as an effective way forward for the community. This was seen as a positive and proactive approach for the community for the community which was overwhelmed by grief and despair associated with suicides.

Our Healthy Clarence Plan

The OHC plan details the objectives and strategies to guide implementation in the first two years of the initiative. The objectives are:

1. To improve access for people at risk of self-harm to treatment, crisis care and care after an attempt.

2. To improve the ways in which workers and the community respond to people at risk of self-harm.

3. To ensure that suitable mental health and wellbeing programs are available in schools.

4. To improve community awareness of mental health. This includes how to access information and services.

5. To improve our connection with the community. To improve early support for people who are at risk of self-harm and to help prevent self-harm.

Under each objective, there are a number of strategies. These strategies reflected the issues identified in the initial report[4] and subsequently informed by evidence from the Black Dog Institute's Suicide Prevention Framework[5].

Governance

The implementation of the initiatives of OHC is overseen by a number of committees and working groups as described in Figure 2.

The Our Healthy Clarence Steering Committee plays a communication, coordination, advocacy and leadership role to drive the development and implementation of the Our Healthy Clarence Mental Health and Wellbeing Plan, and to support its evaluation. The proposed membership of the committee is made up of community members, including two young people, and representatives from the relevant agencies as shown in Table 1.

Figure 3: Governance of Our Healthy Clarence
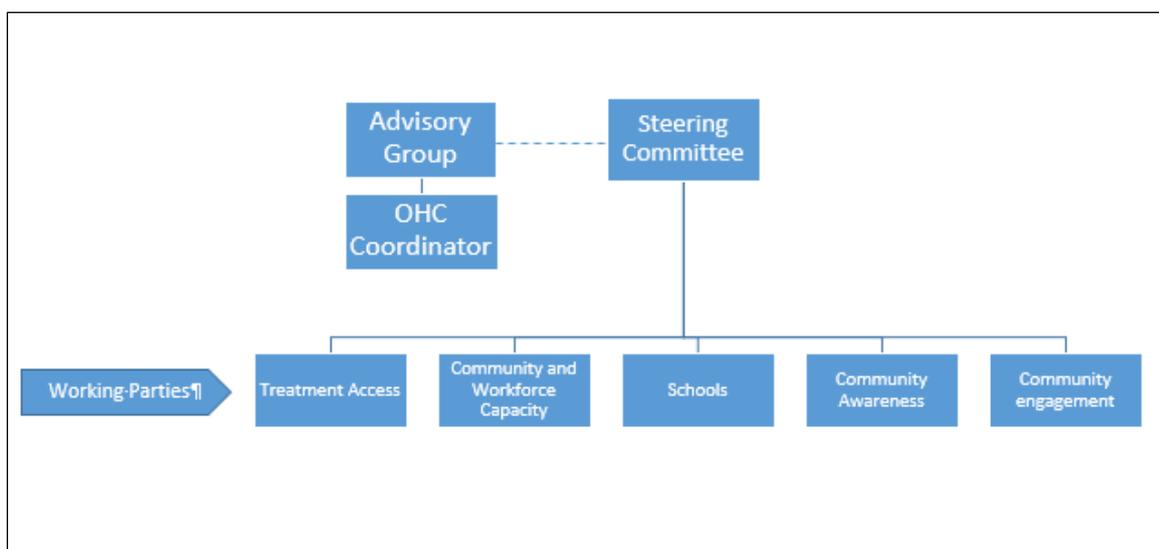
Membership is open to application by any member of the community or relevant agency and is determined by assessing a prospective member's capacity to contribute to the objectives of the plan.

Applications are assessed by all Committee Members and approved when more than half of the members approve the new membership.

Table 1: Our Healthy Clarence Steering Committee Membership

Members	
• Bulgarr Ngaru Aboriginal Medical Corporation	• Department of Education or other Clarence Valley Public School Representative/s
• CHESS	• Department of Prime Minister & Cabinet
• Clarence Valley Council	• headspace School Support
• Clarence Valley Private School Representative/s	• Lifeline North Coast
• Carer representative	• New School of Arts
• Consumer representative	• North Coast Primary Health Network
• Community members (x4, including 2 young people)	• Northern NSW Local Health District
• CRANES	• NSW Police
• CYA (Clarence Valley Youth Action)	• Partners In Recovery
	• Standby Response Service

A dedicated project coordinator was appointed in August 2017 for a period of 12 months. The position focuses on community engagement, coordination and support for the implementation of the Our Healthy Clarence Plan. Funding for this position was supported by a number of the agencies including the North Coast Primary Health Network (NCPHN), Northern NSW (NNSW) Local Health District (LHD), Bulgarr Ngaru Aboriginal Medical Corporation, New School of Arts (NSOA) and Lifeline, with employment, management and supervision through NSOA. An advisory group was established to provide oversight of this position in the context of its cross-sectoral role.

Working parties were established for each of the OHC plan objectives. Membership is open to agency representatives and community members relevant to the objective. While not explicitly stated, these working parties are expected to report to the steering committee on progress of the implementation of the strategies.

Key OHC Initiatives

There were a number of initiatives described by participants as being developed and implemented under the OHC banner. It is acknowledged that this is not an exhaustive list but describes the breadth of initiatives supported under the OHC banner. These initiatives are not listed under each objective/working party as they relate in many instances to multiple objectives.

Training and Capacity Building

Training aimed at building the capacity of the community and organisations to understand mental illness and its signs, identify risks of suicide and support help-seeking and support was implemented in a range of settings. Mental Health First Aid courses, and other mental health awareness courses tailored to specific groups, which aim to build mental health literacy have been implemented in settings across the community including in workplaces and sporting groups. Training tailored to the needs of Aboriginal and Torres Strait Islander peoples has been implemented. Across all the training and capacity building initiatives, it is estimated that over 1500 people have been trained. As an

example of the training provided across the Clarence Valley, the numbers of participants and courses provided by RAMHP in the Clarence Valley are included in Appendix 3.

Postvention Approaches

Postvention refers to the approaches to enable communities prepare for, respond to and recover after a suicide death. A range of postvention strategies have been implemented in the Clarence Valley.

headspace in Schools (hiS) NSW (previously headspace School Support) has supported the Clarence Valley community in suicide postvention since 2015. Postvention support has been provided to schools and to the broader community.

Postvention strategies have included:

- Postvention response management (immediate, short and med-long term) across all secondary schools
- Anniversary planning across all secondary schools
- Development of Suicide communication protocol as a critical component of community response and recovery to suicide

A focus of the postvention approach undertaken by hiS and other agencies has been on sustainable capacity building for teachers, clinicians, students, parents and families including: planning and implementation of school resources to identify local services and enhance the capacity of the school community to engage and refer young people, including strategies of secondary consultation, complex case panel, and debriefing for wellbeing staff and teachers; implementation of workforce training packages to support early intervention, identification of risk and gatekeeper training, and broader mental health literacy; and development and implementation of resources for young people, parents, and families to assist in understanding mental health literacy, risk and warning signs of suicide, support for students who self-harm or suicide attempt, grief and loss, and help seeking.

School Education

There has been a range of initiatives implemented across public and private schools across the Clarence Valley. In the development of the initiatives, schools representatives working collaboratively adopted some key complementary principles including:

- The use of evidence-based programs
- School principals as decision-makers as to which programs are implemented in their schools
- Building the capacity of staff to implement initiatives in mental health with an estimate of 40% of school staff completing Mental Health Literacy training
- Embedding initiatives in school policies and procedures to support sustainability

The strategies implemented in schools have been informed by evidence and aimed to build capacity in schools to respond to the mental health needs of the schools' community and have included:

- Staff in schools across the Clarence Valley have been trained in *Seasons for Growth* an innovative, evidence-based change, loss and grief education program to support understanding of the experience of grief.
- Every secondary setting has developed rigorous postvention plans
- Youth Mental Health First Aid and Teen Mental Health First Aid have been implemented in schools

- Seasons for Healing, a culturally appropriate small group education program for Aboriginal and Torres Strait Islander adults who are managing experiences of change, loss and grief has been implemented in schools
- Other training has included
    - STORM, a skills-based model of suicide risk management and postvention training
    - Reading the Signs
    - Mindblank
- Parent information sessions have been held in schools

Staff from headspace Schools Support have provided programs for schools, guided their response to suicides and provided support for the mental health and wellbeing of students, staff and parents. They have also been members of the steering committee.

Treatment and Support Services

headspace Grafton, operated by GenHealth, provide a range of primary mental health care services for young people 12-25 years with mild to moderate mental illness. The initial announcement for the establishment of headspace was made in early 2017 with the service opening at the end of the same year.

Specialist mental health services in the Clarence valley provided by the NNSW LHD have been enhanced with additional child and adolescent and adult psychiatry services.

Pop-up Hubs

In response to community needs, pop-Up hubs (drop-in centres) were initially established in Grafton & Yamba for to provide:

> *The pop-up hubs have been a great community engagement success especially for young people.* Community Member

- Access to good quality health, well-being and service information
- Supported referral to local services and programs
- Safe community spaces to hold meetings and support groups
- Community activities and events to enhance community connections

The pop-up hubs were initially established for all members of the community, with an emphasis on: young people; parents & carers; and people experiencing social isolation. A hub was later established in South Grafton. These hubs were mainly accessed by young people.

Clarence Youth Action Group

The Clarence Youth Action (CYA) Group is a diverse group of people aged between 12-25 years who advise the local council on issues related to young people. They have been particularly active in relation to the mental health of young people and in 2017 won the Mental Health Commissioner's Community Champion award.

Initiatives for Aboriginal and Torres Strait Islander Peoples

Staff at schools across the Clarence Valley have been trained in Seasons for Growth and Seasons for Healing, a culturally appropriate small group education program for Aboriginal and Torres Strait

Islander adults who are managing experiences of change, loss and grief. There has been a range of other training programs offered tailored to the needs of the Aboriginal and Torres Strait Islander community.

With the support of Bulgarr Ngaru Aboriginal Medical Corporation, there are also services for Aboriginal and Torres Strait Islander young people provided through headspace.

Suicide prevention and support

The Way Back service, guided by the model developed by [Beyond Blue](), and operated by CRANES, provides one-on-one, non-clinical care and practical support for people with suicidal ideation or following a suicide attempt for three months after referral. The program accepts referrals from the Emergency Department at Grafton Hospital, and from Bulgarr Ngaru Medical Service.

Community Engagement and Awareness

There has been a range of approaches to community engagement and awareness. Community engagement has occurred through participation in activities and presentations at numerous community events. For example, a range of activities are held as part of mental health month and the coordinator and the Rural Adversity Mental Health Program (RAMHP) worker attend activities such as the truck Festival and the Jacaranda Festival.

Branding for OHC was developed with the use of a tree as the key symbol. The OHC website has been developed providing key information for the community about mental illness and the initiatives of the OHC. A detailed community engagement strategy is currently in preparation.

There is an OHC Facebook page which provides updates on activities in events in the community which are related to mental health and well-being and supports interaction from the community. It also provides links to a range of mental health resources. In addition there is a specific OHC Facebook page for mental health month.

Using a range of distribution points fridge magnets have been provided across the community with details of key contacts for mental health treatment and support.

Key Findings

Despite OHC being in its infancy, there have been significant achievements for mental-health and well-being for the community of the Clarence Valley. This section presents the key findings and achievements based on the analysis of common themes from the semi-structured interviews

Commitment to Mental Health and Wellbeing

The commitment that mental health and wellbeing are the foundation of OHC was overwhelming. This commitment was pivotal to the collaboration and achievements of OHC. It was also important to the healing that was perceived to have occurred in the community since the OHC was established.

> *From the beginning we were committed to mental health and wellbeing….. It was in response to suicides in the valley but it has always been about mental health and wellbeing….a positive and proactive approach.*
> Service Provider

The focus on mental health and wellbeing for OHC and its plan, as opposed to having a focus on suicide prevention was viewed as positive and proactive for the community. The commitment to mental health and wellbeing was perceived to occur in the context of considerable pressure to focus on suicide prevention and to become a suicide prevention committee. This pressure was perceived as strong and arose from the North Coast Primary Health Network (NCPHN) and in conflict with the views of the Steering Committee and the community. It was perceived that this pressure was related to the funding stream for suicide prevention that the NCPHN held, rather than the needs of the community. In particular, it was viewed that the OHC plan was changed to reflect the evidence based on the Black Dog Institute's Suicide Prevention Framework for NSW[5] to meet the NCPHN's needs, despite concerns expressed that this was not the focus that was wanted by the community.

Common Understanding of Purpose

Participants shared a mostly common understanding of the purpose of the OHC initiative. Common across this understanding were concepts such as:

- Proactive and positive approach to mental health and wellbeing
- Collaboration between agencies and across the communities
- Building the capacity of the community to understand mental illness, to seek help and provide access to treatment and support

> *Those involved have remained mostly cohesive and committed….. This has been one of the best examples of collaborative practice I have seen….*
> Service Provider

OHC was seen as a collaborative approach whereby a range of responses to mental health and wellbeing are coordinated under the banner of the OHC. In this way, it enabled significant advocacy about mental health and wellbeing and supported the implementation of a range of initiatives. While many services had a role in operating as discrete services there was strong collaboration across services in a way that was perceived to not have occurred in the past. Examples were provided where services worked

together on funding applications with a collaborative approach to preparing the submission and to determining which service was best placed to act as the lead agency. This occurred because of the shared purpose of the OHC initiative. It was recognised that OHC enabled services to leverage the benefits of the shared collaboration to achieve the objectives of the initiative and the service.

Key Achievements

Many of the key achievements are highlighted in the section - *Overview of our Healthy Clarence* - with these relating to specific initiatives or services. However, there were a number of other achievements identified that related to the processes of OHC rather than the specific initiatives.

Service Collaboration

The collaboration between services in the Clarence Valley was seen as a major achievement. This was contrasted to previous times where services were perceived as working in isolation, with adverse outcomes for clients. It was perceived that by working together, it improved the likelihood of being able to advocate for new and enhanced services, as well as improved access and outcomes for clients. It was acknowledged that there are still challenges with collaboration, in particular, in a competitive funding environment between non-government organisations, but that services were recognising the benefits of working together.

In addition, there was a perception of collaboration across agencies at senior levels. Examples were provided where collaboration between health, police and education had been strengthened under the OHC initiative with better responses to mental health in the community as a result.

Supporting Healing

The findings suggest that healing is occurring in the community with evidence of optimism in the community. The postvention strategies implemented in the community have been a significant contributor to this healing process.

The strategies have been applied in schools, with the support of hiS and in the broader community. Informed by evidence and guided by hiS, these postvention approaches have been undertaken collaboratively across services and community and are ongoing. These approaches have supported the community in healing and provided positive ways of responding to ongoing challenges including anniversaries of deaths in schools. Resources have also been developed to ensure responses are appropriate to meet future needs.

Schools

There was a perception amongst some of the key stakeholders that the approach taken in schools was exemplary. It was suggested that there had been a major shift in education characterised by a number of features. First, the initiatives were being implemented across schools, both public and private so that students attending the schools experiencing mental health problems, would receive a consistent response irrespective of the schools. This was facilitated by a network of departmental leaders and principals from secondary schools-from public, catholic and independent schools with a high degree of commitment to address the problem.

Second, the leadership in schools at the individual school and at district level was often described as outstanding with a high level of commitment to address mental health and wellbeing in an evidence-based and sustainable manner. It was suggested that this leadership had been maintained throughout the period of OHC and provided valuable insights into the way to address mental health and wellbeing and suicide in schools. As key decision makers, it was felt that it was important to address mental health and wellbeing at the level of principal and district leaders to embed changes in schools.

Third, there was a strong commitment to ensure that there were changes at the system level to support sustainability. This was perceived as important as previous experience suggested there was a series of one-off approaches which made little impact on the overall response at the school level. Representatives from schools also felt they had some sense of control in determining which programs were implemented in schools. Their past experience suggested they were often bombarded by individuals and organisations selling 'products', with these frequently having limited high-quality evidence for effectiveness in the school setting.

It was acknowledged that the approach taken in schools suffered from two key challenges. The approach used by schools focusing on embedding changes is likely to take longer and be less visible than a series of one-off programs that are often implemented in schools. In addition, it was perceived that schools had not communicated as well as they could about the approach that they were taking, with this identified as an area for improvement.

Aboriginal and Torres Strait Islander Community

There was agreement that engagement with and participation of members of the Aboriginal and Torres Strait Islander community had worked well. Representatives from Bulgarr Ngaru were on the Steering Committee and some working parties.

Engagement with members of the Aboriginal and Torres Strait Islander community had been strong, particularly in the Grafton area but less so in the other towns and communities of the Clarence Valley. In particular, young Aboriginal and Torres Strait Islanders in the Grafton area had been engaged with headspace and with the pop-up hubs and supported by the Clarence Youth Action group. There was a perception that there was a need to do more to engage with the members of the Aboriginal and Torres Strait Islander community in areas outside Grafton.

A number of the training programs were also tailored specifically to the needs of the Aboriginal and Torres Strait Islander community, including young people. There had been positive feedback from members of the Aboriginal and Torres Strait Islander community who had participated in the training.

Young People

The engagement of young people in OHC has been particularly supported by the CYA group. Originally supported by council to facilitate engagement with young people, CYA is now independent and auspiced by a non-government organisation (NGO). It was perceived that CYA has been very effective in engaging with young people and providing a voice on issues related to mental health and wellbeing across the community as well as through their involvement in the Steering Committee. Their commitment was recognised by the Community Champion Award from the NSW Mental Health Commission.

Service Access

There was a perception that there have been some improvements in clinical services, including in specialist Mental Health Service provided by the LHD. Increased access to adult and child psychiatrists was reported. There was also a view that the experience of people presenting to ED with a mental health problem had improved.

Change in Media Response

There was a lot of criticism of the way media reported on mental health and suicide in the valley in the past. Supported by [Mindframe](), the Australian Government's National Media Initiative which aims to encourage responsible, accurate and sensitive representation of mental illness and suicide in the Australian mass media, members of OHC has worked with local media to ensure reporting is aligned with the recommendations of Mindframe. It was acknowledged that there has been significant improvement in the way media reports on these issues locally.

Success Factors

Many of the success factors identified by the participants were perceived as inter-related, providing synergistic benefits for the community.

Community Commitment

The commitment of the community to address mental health and wellbeing and suicides was a critical success factor. It was acknowledged that the community forums initiated by community members leading up to the establishment of the OHC provided the foundation for the initiative. It was perceived that the community was in a crisis situation in relation to the suicides that had occurred across the Clarence Valley. In response to this crisis, community members organised forums, lobbied local health services and politicians and demanded action from a range of service providers. It was perceived that this action was the catalyst for developing the coordinated response of the OHC initiative.

Leadership

The leadership of key individuals from the health services was identified as crucial in the early stages of OHC, and as it developed. In particular, the leadership and commitment of Mr Richard Buss, the then Executive Director of Mental Health and Drug & Alcohol of Northern NSW LHD, and Dr Vahid Saberi, then Chief executive of NC PHN was identified as critical to initiating and leading the OHC in the early stages. Their shared commitment to OHC being a mental health and wellbeing initiative was identified as important in setting the tone of the initiative.

It was also recognised that the leadership and commitment of representatives from the council (Dan Griffin and Giane Smajstr [later with NSOA]), NSOA (Skye Sear), Lifeline North Coast (Alistair Donald) and CRANES (Mark McGrath [later with Headspace Grafton]), as well as the RAMHP worker (Sam Osborne) were important in driving the initiatives. This leadership and commitment was complementary to that of the health services and provided connections with the community. The role of staff from the PHN in preparing the plan was also acknowledged.

Committees like OHC experience attrition of its members, requiring mechanisms for handover in preparation for such changes. In the last 12 months, there has been significant attrition on the

committee at the leadership level with the resignation of Mr Buss and Dr Saberi both recognised as key leaders in the initiation of OHC. There was also concern that since the resignation of Dr Saberi, there had been variable representation from the NCPHN. This was perceived as impacting significantly on the committee, with the rotating representatives perceived as lacking understanding of the purpose of OHC in the context of the needs of the community.

Position of coordinator

The position of the coordinator was perceived as being critical to this sort of initiative. This role enabled the initiatives under the OHC banner to be more effectively coordinated and communicated across the services and community. It was recognised that this required resources and was critical in sustaining the initiative.

Crucial to this position was that it was not owned by one organisation, rather it was jointly funded by multiple organisations. This allowed the role of the coordinator to work across organisations, rather than focusing on the needs of one organisation.

> *We need to ensure there is community representation and not dominance by services, which has happened at time. Community can ensure things are looked at more holistically.*
> Community Member

Governance

The governance of the OHC initiative was viewed as an area which needed significant improvements with several challenges identified. It was acknowledged that these concerns are to be expected in the infancy stage of such an initiative.

Steering Committee

There was considerable time taken to formalise the steering committee and the OHC plan with barriers to progress in the early stages including: identifying and bringing together key service providers and community members with the commitment and decision making ability to progress the initiative; ensuring that steering committee members had the capacity to support a coordinated approach, rather than a service specific approach; acknowledging the timing of the initiatives in the context of the community's readiness to move from a focus on grief and despair to hope and well-being; ensuring objective decision making on strategies, informed by evidence; and enabling input from service providers external to the Clarence Valley to support impartial rather than emotional decisions.

Several concerns were raised about the membership and role of the OHC Steering Committee. First, was ensuring there were sufficient community members on the committee, given that after all, this was a community-based initiative. Importantly it was viewed that community representatives need to be from geographical areas across the Clarence Valley and also from specific groups such as young people. Community representatives also had an important role in ensuring that they regularly consulted with the community they represented to ensure they were presenting their views accurately. In addition, it was suggested that community representatives on the Steering Committee need to be 'influencers' in their communities because of the focus on driving the initiatives not just on representation.

Second were a number of concerns about the number of agency representatives. There was a strong and common concern that the membership had to ensure there was not dominance from one particular agency. While this had not been a problem in the early days of the OHC initiative, there was a view that representatives of the PHN tried to dominate the committee and influence decisions in line with the PHN's agenda rather than community needs, specifically in relation to the focus of the initiative on suicide prevention rather than mental health and wellbeing.

It was also acknowledged that it was critical to have decision makers from agencies on the committee. As an example, the representatives from Education were in a position to make decisions for schools, which supported action. In contrast, there was a view that when representatives from agencies were not in decision making positions, there were inevitable delays because of their lack of authority to make to decisions.

There were also concerns with the more recent withdrawal of the NCPHN from the Steering Committee. This had occurred with the transitioning of the operating functions of the committee to a contract commissioned by the PHN. This contract would then be managed by the PHN as part of their commissioning processes. The concerns raised by the participants were common and strong: there was a view that the PHN still viewed OHC as a suicide prevention committee despite the consistent articulation of it being about mental health and wellbeing; the capacity of the PHN to undertake their role of listening to and working with communities, individuals, health professionals and community service providers was diminished by being at arm's length; and their capacity to continue to advocate for the people of the Clarence Valley through OHC, as had occurred in the early stages was also diminished. It is hoped that future negotiations can result in improved relationships with the PHN and concordance between the aims and function of the OHC between the committee and community, and the PHN.

Third, it was widely acknowledged that there were problems with the open membership. This meant that in some instances there were many people in attendance, there was a lack of consistency in members and that people were not always in a position to understand the context of the decisions. Based on minutes of 11 OHC meetings there was an average of 15.6 people in attendance, with consistent numbers since inception (Appendix 2). These numbers meant the decision-making process of the committee had become unwieldy.

Fourth, the mechanisms for accountability between the working parties and the steering committee were unclear. There was reporting to the steering committee from most working parties on progress. However, there was no capacity for the steering committee to ensure the actions identified in the plan for each working party were implemented. The most common example provided was for the actions that were identified relating to Objectives 1 and 2 about evidence-based guidelines and the capacity of general practice to address mental health and wellbeing. Despite numerous requests for updates on these initiatives to the PHN, the Steering Committee members were uncertain as to progress.

Last was the role of the chair of the Steering Committee. The chair of the steering committee had been shared across the NNSW LHD, the PHN and the Council. It is a demanding role and requires time and commitment to drive the plan and support the partnership. There appeared to be no clear processes as to how the chair would be selected. The provision of secretariat support was also critical to this role but there was no clear mechanism for the resourcing of this role.

Working parties

The working parties were established to ensure the implementation of the strategies under each of the objectives. There is no terms of reference for the working parties or criteria for membership. Rather, community members and service providers with an interest in the area outlined under the objective can participate.

Other identified problems with the working parties also relate to the duplication of actions between objectives (see next section). Additional problems relate to the accountability as identified in the section on the Steering Committee and the lack of clarity of the roles and purpose of the working parties.

Advisory group

The advisory group provides oversight of the project coordinator with membership reflecting the agencies which contribute funds to the position. While managed by NSOA, it was perceived this committee was important for ensuring cross-sectoral support and function of the role. There was some confusion about this role with not everyone being aware of its existence or function. Further, for those who were aware it was perceived that the term advisory was confusing and suggested a role different from its intent.

Areas for Improvement

Participants in the consultation process identified a number of areas to improve and sustain the OHC initiative. Some of these areas have already been identified in the sections above, with this section focused only on those areas not already identified.

Plan objectives

The objectives of the plan were identified after a number of planning forums and related specifically to the [Black Dog Institute's Suicide Prevention Framework](#)[5]. There was a common view that the objectives needed to be reviewed and updated based on the results of this evaluation. It was perceived that there was duplication with similar actions occurring under multiple objectives. For example, there was cross over between Objectives 1 and 2 in relation to evidence-based treatment. There was also a view that actions under Objectives 4 and 5 were potentially duplicated particularly around community engagement, and as a result were often grouped together. These areas of duplication meant that people in these working parties were unsure of which one to attend or had to attend both.

Suggestions for refinement of the working parties included focusing on specific target groups (e.g. youth, Aboriginal and Torres Strait Islander people or older people) and/or on settings (e.g. Schools, health care, support services). In this way, and based on evidence, multiple strategies could be applied for each setting or target group. It was perceived that Objective 3 which focused on schools worked well because it had multiple strategies to address the objective which were appropriate to the school setting.

Promotion of OHC

It was perceived that the OHC was becoming more well-known in the community, supported by the branding and the website, and participation in events. However, there were a number of areas where improvements were suggested.

Communication on progress to the broader community

Participants were aware of the significant progress made under the OHC initiative. However, there was a perception that the approach to communicating progress to the broader community needed strengthening. It was suggested the community engagement strategy currently under development could address this and be supported by a multi-media approach.

Branding

There were differing views about the branding. Some participants perceived that it was now widely recognisable across the community as the OHC, although many of these perceived that it was not necessarily connected to a mental health initiative. In contrast, a number of participants perceived that the brand was only recognised by those in the community who had direct experience with OHC. For these participants, it was the lack of connection with mental health that was the most significant problem with the brand.

Website

Some participants suggested that the website needed to be reviewed. In these instances, it was suggested that the website lacked clarity of purpose, lacked ease of navigation and prevented any emotional connection with the viewer and mental health. It was suggested that the website needed to be a resource for the Clarence Community rather than being what was perceived as a focus on the OHC initiative itself.

Lessons

Participants were asked to reflect on lessons from the development and implementation of the OHC initiative which may be applicable to other communities committed to addressing mental health and wellbeing and responding to suicides in their community. Some of these lessons are implicit in the findings in the preceding sections. Explicit lessons articulated by participants are identified below:

Role of the PHN and LHD

The role of leaders in the NCPHN and NNSW Mental Health Services was critical in the early stages. In particular, the leaders of these organisations demonstrated a number of characteristics which were considered crucial and would be needed in other communities implementing similar approaches:

- Responsiveness to community needs
- Commitment to a holistic approach to addressing the suicides with a focus on mental health and wellbeing
- Rapidity in taking action following community forums with connections with the CRRMH who brought expertise to the area
- Time commitment to supporting the stages in the development of the OHC initiatives

- A sense of trust between these leaders, other services providers and the community in their response to addressing mental health and suicides

These leaders were also seen as being key advocates to support future action both in their organisations and more broadly with government.

Focus on Sustainability

The need to focus on initiatives which are sustainable was identified as a key lesson. The examples provided by schools where initiatives were embedded in school policies and systems were viewed as supporting sustainability. The model adopted by headspace in Schools was another example of applying approaches in schools which were considered sustainable. The use of evidence-based approaches also was viewed as supporting sustainability. Mechanisms were needed across different settings to ensure initiatives were evidence-based before implementation.

You can't underestimate the benefits of having one voice for the community to address these issues. Having community commitment, the plan and people working in the one direction was crucial in advocating for services like headspace
Service Provider

It was also recognised that there needs to be an emphasis on sustainability applied to training. Train the trainer models were identified as being preferable to delivering training to individuals directly.

Resources were also identified as impacting on sustainability. Some initiatives funded under the OHC banner were short term. Most participants expressed concern about the short-term funding with experiences of many short-term responses in the past being withdrawn from the community.

Continuing community engagement and feedback

Community initiatives such as OHC community engagement at their foundation. This occurred particularly in the early stages of OHC with community forums, the consultation project and planning workshops. There was a common view that this needs to be continuous across the life of OHC and broadened especially to ensure hard to reach groups were involved. In recognition of this, the community engagement strategy being developed should support this need.

I am concerned that they will cut the funding. There has been funding in the past but it is taken away after 12 months and we are back to square one. The last thing this community needs is things being parachuted in and then taken away.
Service Provider

Another important lesson was ensuring that there are mechanisms to provide feedback to the community on the progress of implementation and on successes. This was an area that was recognised as needing strengthening in the OHC initiative.

Collaboration strengthens advocacy

The achievements in terms of collaboration and partnerships have been highlighted as a key feature of the OHC initiative. This collaboration under the banner of OHC was perceived as crucial for

advocating for services and leveraging benefits for services and the community for programs and funding to meet the needs of the community. It was recognised that services and community members may have different approaches but OHC allowed them to come together with a shared vision and commitment to doing the best for the community. It was perceived that this may not have occurred if the OHC initiative and plan had not been in place.

> *I am out in the community a lot, both in my role and living here. I have noticed a change in the narrative about mental health. People are more willing to talk about it…. When you run into them in the street, at sporting events. Much different to a few years ago…..*
> Service Provider

External evaluation

The views about the impact of the OHC was that it had been effective in addressing mental health and wellbeing. However, there was a high level of commitment to ensuring external and objective evaluation of the initiative. In particular, this was viewed as supporting the review of progress and informing the next steps in the initiative.

Impact

It was widely acknowledged that OHC was formed in response to a high number of suicides in the Clarence Valley. There was optimism in the community that there had been few suicides in the community since the implementation of OHC. However, participants almost unanimously reported that number of suicides was not a measure of the impact of OHC, especially in its infancy. Indeed a number of participants identified that it is likely that there will be more, as occurs in any community. There was a recognition that those involved in OHC and the community need to be prepared for that event.

Participants identified a range of impacts which were viewed as resulting from the OHC initiative which may not be quantifiable but were important for the community of the Clarence Valley. Ultimately it is hoped that the mental health of the community will improve and suicides will reduce over time. But these are considered distal outcomes with a range of impacts more important at this stage.

Change in Community Narrative

There was a common and strong view that the community narrative about mental health and suicide had changed. It was perceived that people were more ready to talk about mental illness and suicide, as well as being more willing to seek help. It was acknowledged that quantitative data to demonstrate this was not available but the majority of participants identified examples of how the narrative had changed in the community and across different settings.

It was also perceived that the level of stigma in the community towards mental illness had decreased. However, it recognised that this still exists with continuous effort needed to address stigma.

Community Optimism

Associated with the change in community narrative was a perception that there was a sense of optimism across the community. At the time when community action had first started, there was a lot of anger and despair in the community. People described the situation as a crisis with anger and

hopelessness common in the community. In contrast, it was suggested that people in the community were more optimistic about the future in the Clarence Valley. It was recognised that this was not solely attributable to the OHC initiative but also to infrastructure programs bringing employment to the community.

Community as the solution

When the community was in crisis associated with the suicides, there was a common view that health services and in particular specialist mental health services were the answer to addressing this problem. This narrative has also changed where people now see the community as the solution with mental health services as one part of the community.

In addition, there was a strong sense in the past that governments have to do something to 'fix the problem'. Now there is a sense that governments are a part of the solution but instead of people asking "Why don't governments fix this problem" they are now asking "how can we as a community sustain these solutions together?".

Collaboration

The impact in terms of collaboration has been described elsewhere in this report. A significant impact of OHC has been collaboration between services which had previously operated independently. This was perceived as important for the services but ultimately would result in improved outcomes for individuals and the community.

Discussion

Evidence supports the community collaboration approach taken by OHC as being effective in addressing mental health and wellbeing in the community[6, 7]. These approaches have benefits, which include: services being responsive to individuals and community needs, reduced dependency on specialist mental health services with improved mental health and wellbeing, and addressing the factors associated with mental health problems[7].

OHC is in its infancy and will require time before more robust evaluation to assess outcomes can be applied. However, the findings suggest significant impacts to date across a number of areas important to the mental health and wellbeing of the community. Further, the commitment in the Clarence Valley to continuing to improve mental health and well-being and prevent suicides through collaboration across the community and in partnerships with services remains strong.

Informed by these findings, the next steps should be decided by the community of the Clarence Valley. To support community engagement it is important that the findings are provided to the participants and more broadly to the community. This section, guided by the findings suggests a number of areas to focus on which may inform the discussion and decisions of the community.

Key Elements of OHC

The OHC demonstrated a number of elements which align to evidence for collaborative approaches to addressing public health challenges for communities. Collaborative approaches with deliberate collaborations across a variety of stakeholder groups to achieve an agreed-outcome have been shown to be effective. In particular they have been shown to be effective when addressing a health area like mental health which is associated with a complex interaction of factors and service responses[8, 9].

These collaborative approaches have a number of advantages including: fostering a unified approach; leveraging of collective resources; achieving collective and agreed outcomes of benefit to partners and the community; cultivating innovation and creativity to solve shared problems; engaging new networks that can help hold leaders and agencies accountable; strengthening credibility of services; promoting broader reach and impact than can be achieved by individual organisations; and maximizing advocacy power[8, 10].

The key elements of OHC which align with evidence for collaborative approaches include:

- Forming **collaborative partnerships** from multiple sectors, community members and consumers, organised as a coalitions or committees, and supported by governance which support engagement, action and accountability [10]
- Having a **clear purpose**, supported by a rationale which is informed by community needs thus providing a vision for the partners and for the community[11, 12]
- Developing a **plan of action**, through a collaborative process to determine goals, strategies and roles and responsibilities of contributing partners, with a focus on multiple evidence-based strategies [12]
- Moving to a **phase of implementation** of agreed strategies building on the strengths within the community, ensuring accountability and feedback[12-14]
- Focusing on **embedding initiatives** to enable changes in systems and structures within the community and to support sustainability[15]

- Supporting **evaluation and feedback** from partners and the community more broadly to refine and improve the initiatives[16]

These lessons can also inform the evidence for community wellbeing collaboratives (CWC). These are based on evidence which suggests that community engagement, ownership and empowerment are more likely if the community identifies an issue in the community, such as mental health, for improvement itself. Through a local process of co-design between a range of community members, CWCs can help to embed environmental, organisational and behavioural changes in their community. The CRRMH is currently building a framework for CWCs to help inform other communities.

Moving from despair to positivity

The findings demonstrate the community has moved from a place of despair associated with suicide deaths to one of positivity. All the approaches applied in OHC have contributed to this process. While the community demanded a focus on mental health and well-being, it is apparent that the postvention strategies applied in schools and more broadly in the community have been important catalysts for the community to achieve a greater sense of positivity. This is not in conflict with the emphasis on mental health and well-being as a positive construct, rather is an essential component and supports the community in healing.

Focus on mental health and wellbeing

There are similarities between the evidence and frameworks for mental health and wellbeing and for suicide prevention. Many of the frameworks for mental health promotion and prevention take a public health approach by addressing the factors that are associated with mental health and acknowledges the influence of individual characteristics and structural and community factors[17, 18]. Similarly, frameworks for suicide prevention focus on risk factors and action across the community[5, 19].

Under considerable pressure, the community insisted on a focus on mental health and wellbeing, rather than on suicide prevention. While the differences may be subtle, that it was important to the community was reason enough to maintain that focus. Given the state of despair when community action first started it was important to focus on a positive dimension which was about promoting mental health and wellbeing rather than on suicide. Based on the results it appears the judgement of the community was correct. These findings also suggest that there are lessons for other communities that are in a situation similar to the Clarence Valley in insisting on a focus on mental health and wellbeing.

Recommendations

1. The focus on community mental health and wellbeing should be maintained
2. The lessons from OHC should be shared with other communities and contribute to the community wellbeing collaboratives

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Planning

Evidence demonstrates that collaborative approaches such as OHC go through a number of phases. Initially the focus of collaboratives is on forming partnerships, planning and coalescing as a team and often takes up to 12 months[9]. Collaboratives then move into implementation phase where agreed strategies and actions are carried out across the partners. The third phase, often overlapping with the second phase, is described as the

phase focusing on sustaining the effective activities of the local partnership and often involves engaging other community entities to support a longer term foundation for the collaboratives operations and sponsored activities[9].

The OHC, is a relatively new initiative. Much of the focus has been on developing the collaborative approach and partnerships. Given the relative short time period OHC has also made significant achievements in the implementation phase. The findings of this evaluation can guide the next stage of planning for the OHC, supporting ongoing implementation with a focus on sustainability.

The current plan provided a foundation for implementing many of the initiatives of the OHC. However, as in any planning process, the context and need changes as strategies are implemented. The findings highlighted a number of areas of which might inform a new plan. In particular, the findings suggest reviewing the objectives to avoid duplication and to consider targeting of specific groups in the community such as young people, Aboriginal and Torres Strait Islanders and older people. Settings such as schools, sporting groups and health care services may also be a focus of the objectives. Importantly the plan should be informed by community views to ensure it continues to meet the needs of the people of the Clarence Valley.

Regardless of the approach and in line with evidence, the next plan needs to ensure that multiple strategies or actions are identified for each objective, with a focus on embedding these into relevant organisations. It also needs to ensure there are key indicators and responsibilities assigned to lead strategies to support accountability, with feedback on progress[16].

Recommendations

3. Informed by the community, develop a new plan to guide the efforts of OHC for the next 5 years focusing on building sustainability.
4. Review the objectives, with consideration given to those relevant for target groups and/or settings
5. Ensure the plan identifies key indicators related to the strategies and lead agencies responsible for delivery

Future strategies

Based on the findings there are a number of principles which may guide decisions for strategies in the next plan. Evidence suggests the need for multiple strategies to promote mental health and wellbeing and prevent mental illness[20]. Multiple strategies across the Clarence Valley have been a key feature of the first plan. As the initiatives mature, and informed by evidence, it will be important that strategies focus on individual as well as on systems and communities to embed changes. Importantly having mechanisms to ensure strategies under OHC are evidence-based and focused on building capacity will support sustainability.

The approaches used to date where initiatives have been tailored to specific groups has been widely supported. This is particularly relevant for young people and Aboriginal and Torres Strait islanders where programs tailored to their needs have been implemented successfully.

Recommendations

6. Ensure multiple strategies are applied for each objective which are focused on individuals, the community and systems, and which build the capacity of the community and services
7. Continue to tailor strategies to specific target groups

Community engagement and communication

Evidence indicates the importance of community engagement in collaborative programs designed to address community mental health and wellbeing[11]. In addition to community engagement to identify key issues, it is essential it continues throughout programs. Not only does it allow reflection and feedback but also support the development of trust and partnerships in the community[11]. The early stages of OHC were particularly successful in terms of community engagement. The level of engagement contributed significantly to the development of OHC and its success. However, based on other community-based initiatives, the need for reinforcing the narrative around mental health and wellbeing, reporting on and celebrating progress and continuing community engagement is required[15]. A community engagement strategy is in development and will be essential to supporting ongoing engagement. This should enable broad-based community engagement, including for hard-to-reach groups and include reporting back on progress to the community.

Communication strategies require a multi-media approach. OHC already uses multiple avenues for media including Facebook, the website, marketing and print and radio media. Strategies to date have been effective but could be enhanced pending the review of the plan.

The website was one communication strategy which was identified as needing review. Websites are important communication tools to reflect the purpose of organisations, initiatives and services. Given the potential of a new plan, it may then be timely to ensure alignment between the new plan and the website to maximise communication. As part of the review of the website, the steering committee may need to consider how the website presents to an unfamiliar community member. The website should be community facing and make it clear how a community member can contribute to the wellbeing of the Clarence valley. There should also be enough information on the website to show the progress of OHC towards its objectives.

Recommendations

8. Finalise and implement the community engagement strategy ensuring
   a. broad engagement across the community
   b. tailored engagement strategies to hard-to-reach groups
   c. inclusion of feedback strategies on progress
9. Review the website in the context of the revised plan

Review of governance

The steering committee has a strategic and leadership role with responsibilities for driving the implementation and evaluation of the OHC plan and its evaluation. Complementary to the steering committee, which although not defined by terms of reference, the working parties focus on enacting the strategies in the plan. Conceptually this governance model has served OHC well, with the findings suggesting the need for changes in membership and function to meet the future needs of the next stages, rather than the overarching model. Given a review of the OHC plan and its objectives it is timely to review governance. Importantly it needs to be recognised that governance is a means to support the implementation of the plan, and not an end in itself.

Steering committee

The need for ensuring a balance between community members and service representatives on the steering committee was identified. Options for representation from different locations and from different target groups was a key finding. The existing steering committee members will need to determine how this occurs, ensuring that those selected are seen as influencers by the community they are representing. The role of community representatives also needs to be considered ensuring that they regularly consult with their communities and provide advice to the steering committee on community concerns.

Initially, having an open membership process has ensured inclusiveness in representation, with limits only determined by the process of application. There are also no time frames for membership with risks of either stagnation or constant turnover. This has resulted at times in the decision making processes becoming cumbersome and potentially ineffective. It has also prevented consistency in membership further hindering decisions. Decisions will be required about steering committee membership to balance inclusiveness and functionality. Potentially this can be addressed by ensuring appropriate and balanced membership and considering time frames for membership to enable consistency in participation and also to ensure new contributions.

Attrition of membership is common amongst services and committees and has occurred with OHC steering committee. Ensuring mechanisms are in places to prepare for attrition in the steering committee is required to ensure continuity in function.

Key decision makers are also essential for the steering committee. The findings relating to the participation by senior representatives of School Education with authority to act and make system changes demonstrates the need for decision-makers with opportunities provided for other service providers to contribute through participation in the working groups.

The chair of the committee is a demanding position which to date has required significant time and energy from those in this role. While not specified and in addition to the capacity to chair meetings, criteria for chair should also reflect a commitment to mental health and wellbeing, and capacity to strategically negotiate and advocate to achieve the outcomes of the plan. The time frame for the appointment of the chair should reflect the demands of the role and ensure the position is shared across the membership.

With a new plan, the need to review the role of the steering committee is essential. The terms of reference for any committee establishes the role, functions and membership of a committee. Importantly it ensures effective governance of the project, plan or service. There is also opportunity

in the terms of reference to reflect on the roles and functions of the working parties and the links and accountability between them and the steering committee.

Working parties

Consisting of representatives from community and agencies, the working parties focus on delivering the plan strategies. The working parties currently do not have terms of reference, and while they have mostly functioned well, their role needs defining to maximise their effectiveness.

Membership reflects the objectives of the plan, with representatives in each working party having an interest in the area and capacity to deliver on the objective. With a review of the plan and potentially new objectives, the membership of the working parties will need to be reviewed ensuring that the members are relevant to the objective and have the capacity to deliver through advice and action. As with the steering committee to ensure renewal, time frames for membership should be specified. This does not mean limiting terms but that appointment ensures the opportunity for new membership.

In the absence of terms of reference, the accountability between the steering committee and the working parties is at best implicit. This does not suggest that the working parties have not demonstrated accountability as it is clear from reports that most have. However, the findings suggest that this is an area which needs strengthening to ensure the plan is delivered to meet the needs of the community of the Clarence Valley. The structure of the steering committee is robust and aids the progress of the initiative. It may be useful to establish some of the same structural elements around each of the working groups to help identify areas for improvement. Ultimately, it would be beneficial to share their actions and progress with the broader community.

Advisory group

The advisory group was established out of necessity to provide oversight of the OHC coordinator position. Its membership was based on the organisations contributing to the funding of the position. This position is dependent on ongoing funding, and at the time of this evaluation lacked clarity in terms of future funding. However, the findings suggest it is a critical role with key benefits associated with the joint contribution of funding. In addition, this group ensures that the oversight of the role of the coordinator occurs across agencies, which may be necessary in the future regardless of funding sources. That there is confusion and uncertainty about the existence and function of this advisory group needs addressing. If it continues, there needs to be clarity about its role and functions and relationship within the overall governance.

Recommendations

Steering committee

10. On finalisation of the new OHC plan, the membership of the steering committee should be reviewed with consideration to:
    a. Ensuring balance between the number of community members and service representatives
    b. Community members being influencers in their communities and representing locations and/or specific target groups
    c. Time frames for appointment to and review by the steering committee
    d. Service representatives are decision makers

     e.   Mechanisms are in place to manage attrition of members

11. The appointment of the chair should be based on their capacity to chair meetings and strategically negotiate and advocate to achieve the outcomes of the plan

12. The terms of reference require review in the context of the new plan and ensuring accountability between the steering committee and the working parties

Working parties

13. Develop terms of reference for the working parties with purpose and functions relevant to advice and delivery of the strategies in the plan

14. Membership of the working parties needs to reflect the objectives in the plan

15. The terms of reference need to ensure accountability between the working parties and the steering committee

Advisory group

16. The functions and role of the advisory group need to be made explicit with clear terms of reference, membership and relationship within overall governance

Ongoing evaluation

There is a strong commitment to evaluation of OHC, as is reflected in the role of the steering committee in driving its evaluation. Evidence frequently describes the difficulties in evaluating community-led programs such as OHC[21]. Despite these challenges, the importance of evaluating the processes and ultimately the outcomes is widely supported[21].

The importance of evaluating these sorts of initiatives is based on the need to ensure the outcomes are achieved for the community, but also that lessons are learned to help refine the implementation for this and similar approaches. With a revised plan including indicators associated with implementation, there is support for ongoing evaluation.

Ultimately it is expected that the mental health and wellbeing of the community will improve. There is a range of indicators at local government level which will further contribute to evaluation, but these will take longer to achieve. The commitment to engage with the community to receive feedback on implementation will deliver ongoing evaluation as to the effectiveness of the OHC initiative.

Recommendations

17. Maintain the commitment to evaluation of the OHC initiative

18. Ensure the results of the evaluation refine the initiative and are shared with other communities

Conclusion

In the context of the ambitious nature of OHC, there has been significant progress and impact in the two years since its inception. This is a credit to the members of the steering committee, the working parties and importantly the community members who initiated this journey. The findings of this evaluation on the process of the development and implementation of the OHC to date suggest many benefits to individuals, services and the community. These benefits are in line with findings from similar initiatives which demonstrate many positive outcomes for individuals' mental health and

wellbeing, for the functioning of communities and for the responsiveness of services to meet community needs[7]. Importantly there are many lessons to be learnt from the OHC initiative which can be shared with other communities. The CWCs will support these learnings with OHC as a key contributor.

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Appendices

Appendix 1 Methods

Sample

Interviews were conducted with key stakeholders who were over 18 years of age from the Clarence Valley LGA, who had been involved directly or indirectly with OHC or any of its strategies. Key stakeholders from organisations external to the Clarence Valley were also included if their organisation had contributed in any way to the OHC initiative. Stakeholders included: consumers, carers and interested community members; service providers from mental health, drug and alcohol and other community support services; and representatives from other agencies such as Departments of Education and Police.

The sample for the interviews was initially provided by the OHC steering committee members and the OHC coordinator. These participants were initially contacted by the OHC coordinator about the evaluation and given a participant information statement which disclosed the full details of the research to allow for informed consent, and a consent form which collected contact details. Interested participants were asked to return their consent form to a member of the Centre for Rural and Remote Mental Health (CRRMH) research team. On receipt of consent, a member of the research team contacted each participant to schedule an interview.

Interviews

Semi-structured interviews were conducted face-to-face, or by telephone if participants were unavailable on the day. One-on-one and group interviews were conducted depending on the preference of stakeholders. The interviews were audio-recorded to allow for analysis of common themes. The interviews took place between the 16th of April and the 1st of June 2018.

Fours domains were included in the interview instrument: understanding of the OHC initiative; relationships and collaborations; engagement with the community; and sustainability. Within each of these domains, a series of questions were asked of the participants. Participants were provided with the opportunity to make additional comments.
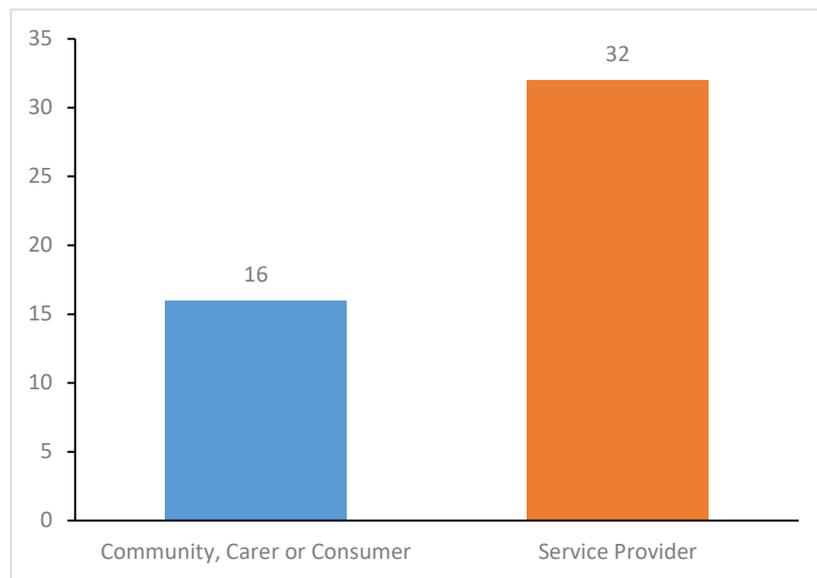
Analysis

Interviews were audio-recorded. For the purpose of this report, a modified thematic analysis was applied to identify common themes.

Participants

A total of 48 stakeholders were interviewed for this evaluation. The category of each participant is shown in Figure 2.

**Figure 2: Participants by category**

Of the 48 participants, two-thirds (n=32) were service providers and the remaining one-third (n=16) were community members, carers or consumers of mental health services.

Appendix 2   OHC steering committee attendance
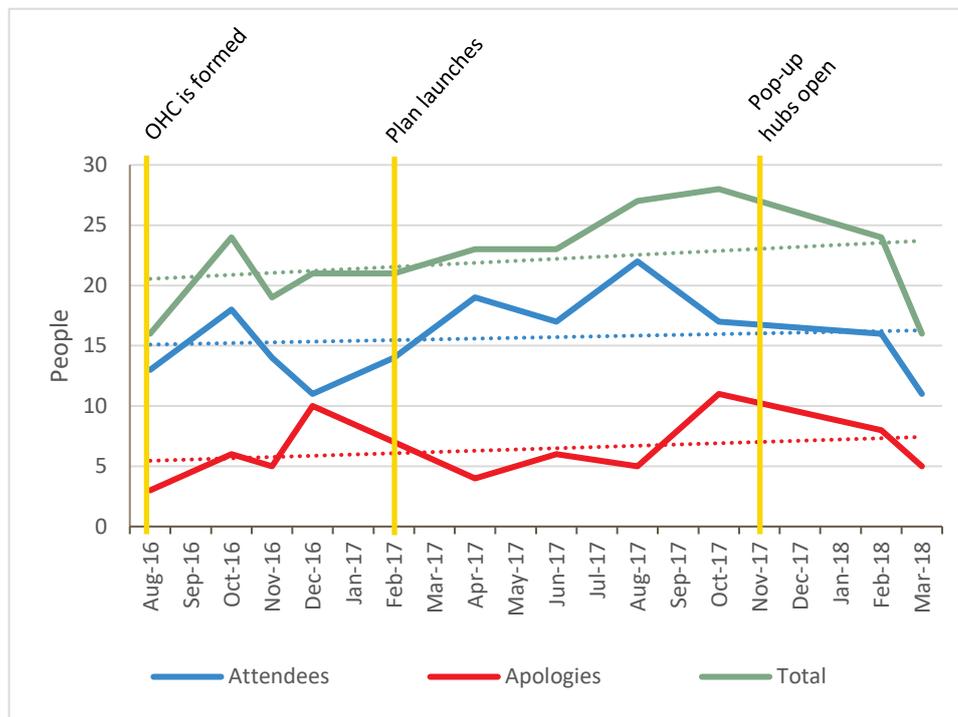
This is a graph of steering committee attendance and apologies according to the minutes of the 11 meetings available. The solid lines show the number of people and the dotted line shows the overall trend in membership. There is clear documentation of the actions of the steering committee, which makes it possible to monitor membership overtime and shows that average attendance has been 15.6 members. This graph shows that a) commitment to the initiative has remained relatively constant of the last two years, and b) that membership has not increased to bloated levels. It should be noted that the March 2018 meeting was an out of session meeting to discuss the role of the NCPHN in OHC and had lower attendance due to this. Prior to the formation of OHC there was also a Mental Health Combined Agency Meeting, which was attended by 24 service providers and professionals.
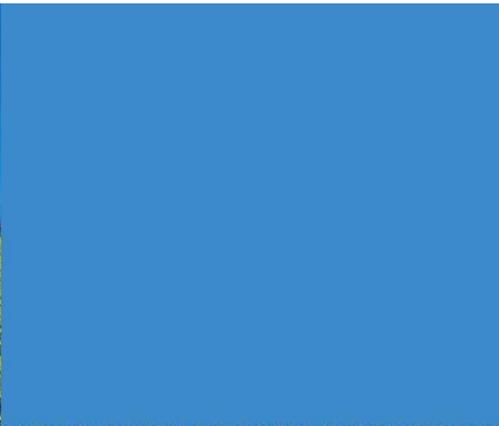
Appendix 3 RAMHP training for OHC
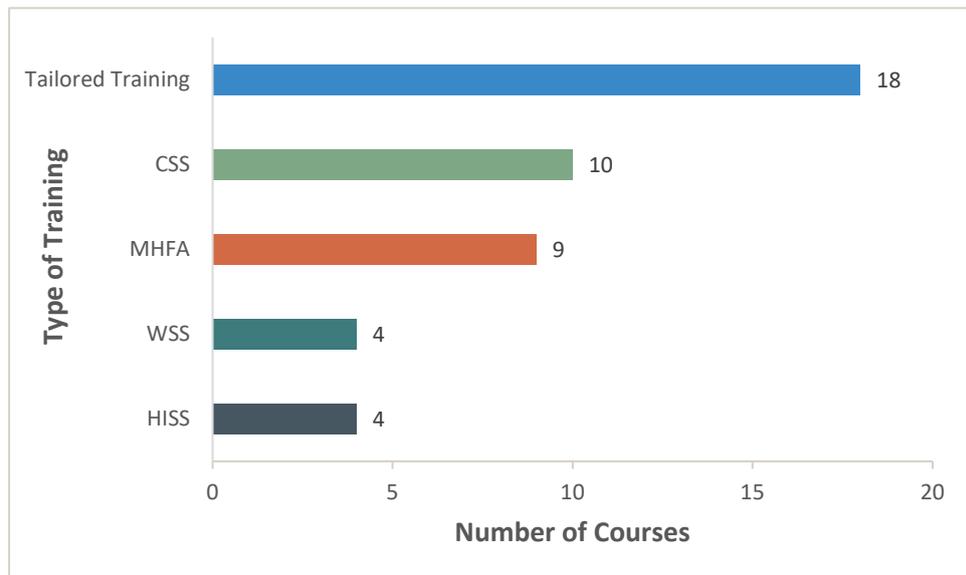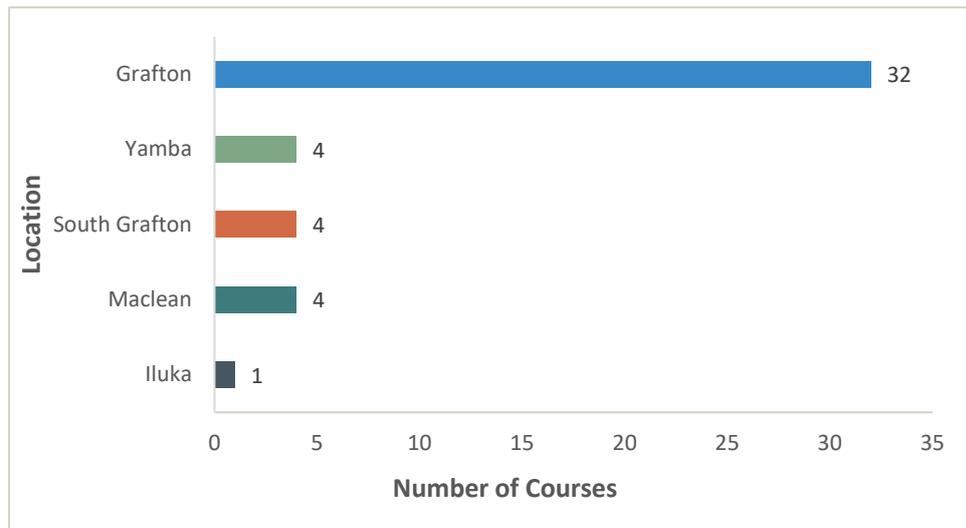
Total participants = 885

The charts above outline the training undertaken by RAMHP Coordinator Sam Osborne in the Clarence Valley between February 2017 and June 2018. CSS = Community Support Skills, MHFA = Mental Health First Aid, WSS = Workplace Support Skills and HISS = Heavy Industry Support Service.

Examples of tailored training include: Introduction of RAMHP and access to local services; Our Healthy Clarence Journey; Suicide Bereavement in Children and Adolescents; Suicide Risk Assessment and Safety Planning; Supporting young people and children bereaved by suicide; Understanding and Responding to Trauma.

More detailed information on training impact and RAMHP activities can be prepared on request.