

Meeting of State and National Mental Health Commissions and International Mental Health Leaders

11 and 12 March 2013 Sydney, Australia

**Hosted by the National Mental Health Commission of Australia
in partnership with the New South Wales Mental Health Commission
and the Mental Health Commission of Canada**

Meeting Communique - The Sydney Declaration

International, National and State guests assembled in Sydney for two days to discuss ways to bring about change for the benefit of people living with and recovering from mental health difficulties, their families and supporters and the wider community.

Two days were spent in a spirit of joint purpose to share experiences, learn from each other, create connections and explore opportunities for future partnerships and collaborations at national and international levels. People with lived experience of mental health issues and family members were present throughout the discussions, which enhanced the sharing of experiences and learning, and the identification of opportunities and partnerships.

The discussions focused on five areas:

1. Indigenous mental health
2. Seclusion and restraint
3. Work and mental health
4. Knowledge exchange
5. International benchmarking

These five areas were chosen following a number of suggestions made before the meeting. The areas selected are not exhaustive, rather they represent issues that were of significant interest to the participating organisations and leaders, and they align with a number of the key priority areas of focus for the National Mental Health Commission of Australia.

The participants agreed to issue this declaration setting out their commitment and dedication to pursuing actions on these five areas. This declaration acknowledges that people's lived experiences inform the focus of this future work and that makes improvements towards a fully contributing life for people living with mental health difficulties, their families and supporters is the goal. The declaration is issued recognising that actions to be taken forward will be determined locally.

The declaration has been produced to help underline the participants shared and common commitment to advocating for, supporting and driving change. This commitment

will be further served by continuing collaboration and partnership and by creating opportunities for further dialogue and learning.

1. Indigenous Mental Health

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

Together we commit to adopt the Wharerātā Declaration with its vision of *Healthy Indigenous individuals, families and communities*.

<http://www.fnhma.ca/conference/2011/FNHMA%20English/Workshop%20L.pdf>

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

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

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

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

1. Include and value Indigenous perspectives and practice in our respective programmes of work.
2. Advocate for and promote trauma-informed care approaches to strengthen mental health practice across all our communities.
3. Contribute to the on-going development of Indigenous leaders in mental health by supporting Indigenous peoples to collaborate and learn from each other domestically and internationally (for example with and through the International Initiative for Mental Health Leadership, IIMHL).

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

2. Seclusion and Restraint

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

We also recognise that families, supporters and service providers are extremely concerned about the use of seclusion and restraint and the lack of information and response following the use of these practices. This underlines the need for reflective practice and continuing practice improvement. The use of involuntary practices and specifically seclusion and restraint is a complex area and together we will work to bring an end to the practices of seclusion and restraint across our mental health systems. To help this, we commit to:

1. Sharing knowledge and experience, including how to implement models of good practice in ending seclusion and restraint practices.
2. Advocating for the engagement of people using services, their families and communities in the on-going development of services, particularly around working together to bring an end to seclusion and restraint.
3. Finding common definitions to facilitate improved data collection and indicators to report on seclusion and restraint to help measure the extent to which these practices are ending.
4. Supporting one another to bring about the changes needed to get evidence regarding improving patient safety and occupational health and safety issues that help underpin this work.
5. Consider the need for possible legislative mechanisms to support bringing an end to seclusion and restraint practices.

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

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

3. Work and Mental Health

We recognise that addressing the relationship between work and mental health has benefits for people with mental health difficulties, broader communities and economies. The participation of people in meaningful work is a matter for governments, public services agencies, businesses large and small, NGO's and communities. The workplace can contribute to mental well-being and play an essential part in helping people and families attain their full potential in living a contributing and meaningful life.

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

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

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

1. Involving a broad stakeholder group – comprising labour organisations, government, corporations, unions, the mental health community, providers, employees and employers and others in bringing about sustainable change.
2. Leading by example - as mental health organisations and departments, we need to be leaders and champions for this agenda and ensure our own workplaces are psychologically healthy and safe. We should also model a workplace that includes people with lived experience and one that supports those who have a caring role.
3. Being inclusive – by including small and medium organisations in what we do and acknowledging that they are often the most impacted by economic, workplace and social pressures.
4. Supporting employers to create mentally healthy workplaces, adopt family and carer friendly employment practices, and improve opportunities for employing and

sustaining the employment of people living with mental health difficulties and challenges¹.

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

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

1. Work collaboratively with employers to create and sustain a psychologically and physically healthy and safe work environment.
2. Develop a parallel and linked agenda on access to work and maintenance in work for those with severe mental illness.
3. Promote the collection of qualitative and quantitative data to demonstrate which programs, interventions and tools are effective and why.
4. Share best practices and evidence on what works and what doesn't.
5. Help develop clear expectations of the benefits of standards for psychological health and safety in the workplace through regulatory frameworks and guidance for employers.
6. Share and advocate the use of the voluntary *Standard for Psychological Health and Safety in the Workplace* developed by the Mental Health Commission of Canada.

4. Exchanging Knowledge

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

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

5. International Benchmarking

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

¹ The Mental Health Commission of Ireland has no mandate for developing employment services.

international borders by building on work under way to help creatively achieve our aspirations.

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

In Conclusion

We all feel we have benefited from these two days of discussions, and we will endeavour to find ways of continuing these and other collaborations. The next opportunities are in Perth in July 2013 for Australian based organisations and then in the UK in June 2014 during the next International Initiative for Mental Health Leadership's international exchange programme and network event.

Declaration endorsed by:

Participants in the Sydney meeting are listed below. Each of the people listed has endorsed the declaration on behalf of the agencies they represent and / or as individual participants.

National Mental Health Commissions

Australian National Mental Health Commission: Chair, Professor Allan Fels
Commissioners: Peter Bicknell, Professor Pat Dudgeon, Sam Mostyn, Professor Ian Hickie, Professor Ian Webster, Jackie Crowe, Janet Meagher, Rob Knowles
Robyn Kruk Chief Executive Officer, Georgie Harman Deputy Chief Executive Officer, Catherine Lourey Director Report Card, Jane Moxon Director Policy, Strategy and Projects

Mental Health Commission of Canada – Louise Bradley President and Chief Executive Officer, Sapna Mahajan, Director Prevention and Promotion Initiatives, Nicholas Watters, Director Knowledge and Innovation

Mental Health Commission of Ireland – Martin Rogan, Commission Member and Dr Patrick Devitt, Inspector of Mental Health Services

New Zealand Mental Health Commissioner – Dr Lynne Lane

Australian Mental Health Commissions

New South Wales Mental Health Commission – John Feneley Commissioner, Professor Alan Rosen Deputy Commissioner

Mental Health Commission of Western Australia – Eddie Bartnik Commissioner, Barry McKinnon Chair of the Mental Health Advisory Council

Queensland (Mental Health Commission in development) – Liz Powell, Director Queensland Mental Health Commission Transition Unit
Australian States and Territories

Australian Capital Territory – Dr Peggy Brown, Director General, Health Department

Northern Territory – Mike Melino, A/Executive Director, Health Services Division
Department of Health, Bronwyn Hendry, Director Mental Health Services

South Australia – David Davies, Executive Director, Mental Health and Substance Abuse

Tasmania – Nick Goddard, CEO Mental Health Services, Department of Health

Victoria – Paul Smith, Executive Director, Mental Health, Drugs and Regions,
Department of Health

International guests

Rose Sones-Lemay, Chair Whararata Group and Strategic Policy, Planning and Information, First Nations and Inuit Health, Health Canada

Geoff Huggins, Deputy Director of Health and Social Care Integration, Scottish Government, Edinburgh, Scotland, UK

Professor Harold Pincus, Director of Quality and Outcomes Research, New York Presbyterian Hospital and Columbia University, New York, USA

Dr Ken Thompson, Chief Medical Officer Recovery Innovations and Pennsylvania Psychiatric Leadership Council, Pittsburgh, USA

Facilitator

Gregor Henderson, UK

Also in attendance:

Australian Institute of Health and Welfare – David Kalisch, Director, Gary Hanson, Unit Head Mental Health Services and Palliative Care Unit

Australian Bureau of Statistics - Paul Jelfs, Assistant Statistician leading the Social Analysis and Reporting Branch

Comcare – Paul O'Connor, Chief Executive Officer

Acknowledgements

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- Commissioner John Feneley and his team at the Mental Health Commission of New South Wales
- President and CEO Louise Bradley and her team from the Mental Health Commission of Canada
- Rose Sones-LeMay, International Coordinator at the Wharērātā Group and Health Canada Community Development and Capacity Building (First Nations & Inuit)
- Dr Lynne Lane, New Zealand Mental Health Commissioner
- All the Australian organisations who gave their time, input and support.
- All those who contributed to the meeting papers and discussions
- Australian National Mental Health Commission staff, especially Joan Reeves
- Special thanks to Gregor Henderson, UK, Facilitator of the Meeting