Queensland Mental Health Commission

Homelessness and Mental Health

Gold Coast Convention and Exhibition Centre

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# Current policy trends and what they need to achieve for consumers

## Welcome and acknowledgements

Thank you to the Council for Homeless Persons Australia and the National Mental Health Council of Australia for the invitation to speak today and I respectfully acknowledge the traditional owners of the land upon which this event is taking place. I would also like to pay my respects to the Elders, both past and present.

I also acknowledge the people living with mental illness and drug and alcohol use problems, their families and carers. We must remember that a helping hand, a listening ear or a kind word could make such a difference to their lives, in a society where they too often feel excluded.

## Current policy trends

I have been asked to talk about current policy trends and what they need to achieve for consumers. I will do my best to address the topic!

Policy is never static. It is continually evolving and impacts on funding and services. While this can be challenging but it also presents us with opportunities to inform the policy debate, learn from our past successes and failure and adapt to new and emerging community needs.

The conversation in social policy networks often re-iterates three concepts:

- Consumer focused, person centred
- Collaboration around complex or wicked problems
- Implementation – how to turn good policies into good outcomes for individuals and communities

Queensland Government

What do we mean by consumer focused, person centred?

- We mean that service users should be engaged at all levels of system design, deliver and evaluation.
- We mean that service users should have choice and control, people should be able and expected to exercise their rights and responsibilities.
- We mean that when service users have difficulty exercising their rights as citizens we should provide supports to assist them rather than making decisions for them.

Is collaboration so different from consultation, cooperation, and coordination?
Yes, it is. Consultation, cooperation, coordination can be time consuming, difficult, intellectually and personally challenging. But done well, in a stable environment, individuals can get on with their respective roles.

Collaboration requires compromise, it requires continual compromise and revisiting of agreed roles. Collaboration requires:

- A common vision focused on outcomes
- Leadership, and potentially changing leadership
- Positive relationships
- Respect for diversity
- Discussion, information sharing and on-going learning
- New accountability and incentive mechanisms, often very difficult in bureaucracies

Some time ago I came across an excellent article by Jake Chapman in a Demos publication about the very predictable outcome when there has not been sufficient attention to accommodating different perspectives and agreeing a common vision from the beginning in complex policy areas, that is those which require a collaborative approach. Some of you will recognise them:

1. Unintended consequences start to arise
2. Delivery targets are not met in inter-related systems – others think implementers are letting things drift
3. Interference from others
4. Interventions required to cope with the events
5. Escalating to acrimony and blame between senior managers and implementers

Is implementation so bad?
Let me give you two examples:

- At an international meeting I attended recently, people were starting to talk about reducing the time from 'promising practice' to implementation from the current lag time of 15 years. Think back to 1999. How much has changed since then? Can we really be content with good ideas hatched in 1999 being implemented in 2014?

- John Mendoza's ConNetica Consulting's recent Obsessive Hope Disorder report paints a picture of 30 years of world leading promises, policies and plans in mental health in Australia, not implemented.

## The Commission

David Richmond (Chair of the 1983 Richmond Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled) in the introduction to Obsessive Hope Disorder suggests that:

*There is a void waiting and needing to be filled – perhaps by entities such as the recently established Mental Health Commissions and Commissioners*.

And so to the Queensland Mental Health Commission.

There are Great Expectations of us.

- Great expectations by people like David Richmond and Brian Burdekin
- Great expectations by consumers, families and carers
- Great expectations by politicians and communities
- Great expectations by clinicians and other service providers in the public, private and non-government sectors.
- Great expectations that policies will be implemented, that resources will be acquired, that demand for high cost in-patient services will be reduced
- Great expectations that all government agencies will miraculously come together to focus on the needs of consumers, rather than their individual agency outcomes.

The Commission was established on 1 July 2013 to drive reform towards a more integrated and recovery orientated mental health, drug and alcohol system to improve the mental health and wellbeing of Queenslanders.

The model chosen by Queensland can be described as 'lean and focused', to drive change through setting direction rather than using funding or oversight powers as levers. Agencies are required to 'take account of' our directions. Developing partnerships and effectively collaborating with others is the cornerstone of how we do business, drawing on the expertise of many particularly consumers and their families and carers and the people who work with them.

A real challenge for us is to meet the expectations of our many stakeholders – consumers, their families and carers, professionals working in the mental health, drug and alcohol system, and other organisations be they community based, public, private or academia.

My approach is to do a few things, do them well, and then do some more. There are many ideas of what needs to be done, we need to find strategies to get them done, and when they are done, make sure the evidence is there to see if they have made a difference.

Then do some more.

## Advisory Council

The Commission is supported by the Queensland Mental Health and Drug Advisory Council of 12 chaired by Prof Harvey Whiteford. Council members include consumers and family members, academics and service providers, including a number with a strong background in drug and alcohol.

## A strategic plan

A whole-of-government mental health, drug and alcohol strategic plan as required by our legislation and due for public release in the very near future, will underpin the reform program.

The Commission has undertaken extensive consultation throughout Queensland including in regional areas to develop the plan. We heard from over 740 people through regional forums. It was good to see officers from public and community housing at many of those forums hoping to find avenues that would see better outcomes for the people they were working with.

We have also sought the views of clinicians, the non-government sector and government service providers. We received many submissions from service providers and researchers about the best way forward to address specific issues.

But a document by itself does not achieve reform – what it does is provide focus. Only by setting up the necessary structures and processes, both formal and informal, can any plan make a difference.

Implementation is the key. The plan includes a number of shared commitments to action that will drive implementation.

***The vision in the plan is:***
A healthy and inclusive community, where people experiencing mental health difficulties or issues related to substance use have a life with purpose and access to quality care and support focused on wellness and recovery, in an understanding, empathic and compassionate society.

It is worth noting that this is a much debated vision, almost every phrase has been contested and revised. For instance, the early drafts had a 'mentally healthy' community but this has been changed to simply 'healthy' to emphasise the importance of the physical health of people with a mental illness. In a nutshell, it is not good.

The outcomes we have articulated are based on those developed by the National Expert Reference Group and the National Drug Strategy 2010-2015. We haven't gone off and developed our own new and different set. We steal with style. We do not re-invent. It is a waste of time and resources.

The outcomes cover the spectrum from a population with good mental health and wellbeing, reducing stigma, people having better physical and oral health to people being able to have lives with purpose. Over the coming year we will be identifying what specific indicators are pertinent to Queensland and I would like us to find at least one in the homelessness area. As Travis has pointed out, there are plenty of statistics, let's use them to develop some indicators that will inform decision making to guide future policy and service directions. Statistics gathered but not used in policy development, planning or review are only useful for filling the days of statisticians.

## Homelessness and mental health

There have been considerable changes in homelessness and housing policy and services in Queensland over the last two years. In 2013 the Queensland Government introduced it Homelessness to Housing 2020 Strategy that aims to half the rate of homelessness in Queensland by 2020.

Many organisations throughout the State have work tirelessly to address these issues. Despite this work, people continue to be without stable accommodation.

To effectively reduce homelessness we need to address its causes.

The links between mental health and homelessness are well known. People living with mental health problems are at higher risk of becoming homeless. Those who are homeless are at higher risk of developing mental health problems.

What do we know now?

1. The Micah Brisbane Vulnerability Index Register indicates that as at 30 June 2013, almost half of homeless people in Brisbane had previously or were receiving mental health treatment and 30 per cent had received involuntary mental health treatment in the past.

2. 78 per cent of these reported substance abuse issues but only 40 per cent had received substance abuse treatment.

3. headspace reports:
    - between 48 per cent and 82 per cent of homeless young people have a diagnosable mental illness
    - homeless young people are at greater risk of suicide.

So as we work to reduce homelessness we must also ensure those who remain homeless are able to access services to improve mental health and wellbeing.

## Work underway

These is a significant inter-agency project underway in Queensland to address demands on social housing and in that context we have work underway to see what can be done to improve the likelihood those who have stable accommodation, including through social housing, are able to maintain their tenancies.

The Commission has engaged the Institute for Social Science Research at the University of Queensland to undertake a review of systemic issues for social housing clients with complex needs. Its main focus is an assessment of how the Anti-Social Behaviour Policy is being implemented and its impact on people living with mental illness.

The report includes case studies of the challenges faced by 12 social housing tenants living with mental illness from across Queensland. They have all had at least ASB strike and some had had three. They provide a powerful insight to the complex issues confronted by social housing tenants and housing workers.

The findings may not be surprising to those working in the homeless sector but they include:

- Tenants rarely access supports which might assist them to retain their tenancy
- Tenants are confused about the policy and its implementation
- There is a need for better integration between housing and mental health services.

The report will be finalised by the Commission later in 2014. It will inform the Commission's first Ordinary Report to be tabled in the Queensland Parliament.

The Ordinary Report will include recommendations about the way forward and how best to support social housing tenants living with mental illness to maintain their tenancies and have access to stable accommodation.

The ever present challenge will remain – getting those recommendations implemented. This will be an early test of us, but we have been doing our ground work and I am hopeful we will deliver. By deliver, I don't mean simply a change in policies and processes, I mean a change in the likelihood that people with mental illness and drug and alcohol problems will have stable housing.

Thank you for your time and attention.

# # # ENDS # # #