Queensland Mental Health Commission

Partners in Recovery

19 March 2015

Queensland Mental Health Commissioner Speaking Points

Logan Entertainment Centre

Acknowledgements

- I acknowledge the traditional owners of this land where we are meeting today, and pay respects to their Elders, past and present. I acknowledge the other Aboriginal and Torres Strait Islander people among us here today.
- I also acknowledge the people living with mental health and drug and alcohol problems, their families and carers.
- And thank you for the invitation to return again this year. For those of you who have come back for a repeat performance, I have left the gardening and the knitting at home this year – still relevant but time moves on.

Theme

- I see from the letter of invitation that this forum is about consulting and contributing to system change. Simple words, complex problems.
- So I thought I'd tell you about how the Commission has been measuring its own performance in consulting and contributing to system change. And then talk briefly about how you can help us do our job better. Then together we can make the system better.

Performance of the Commission

- The Commission was established to enhance the mental health and wellbeing of Queenslanders through strategic planning, monitoring and review, and prevention, early intervention and community awareness strategies.
- The success of the Commission lies in its capacity to influence others, in particular policy makers, service funders and service providers to work in a collaborative way

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to best meet the needs of individuals, communities and workplaces to improve mental health and wellbeing.

- If we are to influence, it follows that our advice must be taken. If our advice is to be taken, it must be relevant and credible. If it is to be relevant and credible, it must include the wisdom of lived experience alongside professional and academic expertise.

- Last year we set about finding a way to measure the difference we make, including our effectiveness at developing partnerships and influencing others to contribute to better lives.

- Thank you to all the 580 people who responded to the first survey of our effectiveness earlier this year. Your insight resulted in 20 recommendations that are helping us prioritise our work.

- Many of the views expressed resonate with my perception of what we had managed to achieve in our first year, of what we could have done better, and of some of the challenges ahead.

- Greater focus on drug and alcohol issues is already in our work plan, as is a strategy to engage more meaningfully with a wider range of consumers, families and carers.

- Mechanisms that incorporate input from frontline staff across the State in all sectors, as well as management, are challenging, but we will continue to endeavour to do this. I am concerned about a perception that the views of people from culturally and linguistically diverse backgrounds are not well represented, and acknowledge that the focus in our work to date has been to see how generic policies and practices, such as legislation, are inclusive, rather than consider when special provisions need to be made.

- Awareness and promotion is also on our work plan for this year. Not only must we resolve what needs to be done, but also by which level of government and with what resources.

- We will continue to survey and assess our impact in everything that we do, to check: have we been inclusive? Has our research been useful? Have our recommendations changed WHAT ACTUALLY HAPPENS? The best report in the world is of no use unless it informs decision-making and action.

Working together for system change

- The case for system change is made time and time again – but let me make the case from the perspective of an individual in public housing.
- This case study is from a project we did that looked at systemic issues for social housing clients with complex needs.

Case study – social housing

- Paul lives in a two-bedroom duplex dwelling with two dogs and a cat. Paul does not work and lives off his disability support pension. He completed schooling to grade 9. When interviewed in 2014 he had been issued with a 'first-strike' under the anti-social behaviour policy for damage to property.
- Paul was diagnosed with Bipolar when he was 16 years old. He is distanced from his family and suffers from chronic pain from an assault that left him with a head injury. Paul self-medicates with speed and marijuana.
- His mental state worsened following an assault on the doorstep of his residence. When questioned, the Department of Housing and Works which issued the "first-strike" was not aware of his Bipolar diagnosis or any current drug and alcohol abuse, although it was aware of his history of drug addiction.
- Following the assault, Paul wished to be transferred to a different location. He believes his perceived lack of safety is affecting his mental state.
- Paul was not receiving support from any services. The DHPW worker attempted to re-engage an agency to assist Paul. This was no longer a viable option, as Paul no longer trusted this service. No other attempts were made and no adjustments were made for Paul's mental health or drug and alcohol problems.
- According to the DHPW worker, a half-day training session was conducted to explain the ABS policy. The rest of the training occurred on-the-job.
- Paul expressed his views about the illogical nature of having public housing for people with mental illness and then evicting them for their behaviour.
- It is clear that there has been a breakdown in communication between the Paul and the DHPW, in part due to Paul's inability to effectively advocate for himself.

- In Paul's case, the ASB policy was implemented by the book – the damage to the unit was serious and justified a first strike**. I note that this policy has been flagged for review, however under the current rules,** if this behaviour continues, further strikes will be issued and eviction may follow.

- An alternative approach is to say that DHPW policies need to appreciate the effect of mental illness on behaviour, and better integration of mental health and support services is needed to address the behaviours without jeopardising the tenant's housing.

- In sum, the major themes from this case study are the lack of advocacy for the tenant, the DHPW's understanding of mental illness issues, the perceived stigma of being labelled "antisocial", and lack of integration between housing and support services.

- Let me give you another very different, much briefer example.

- Sue emailed me last week. She had been in Lowson House for many years and is still upset at the lack of oversight in our mental health wards. She wants nothing for herself. She simply wants INDEPENDENT OVERSIGHT WITH TEETH, to protect the interests of involuntary patients.

- We will continue to advocate for that in the review of the Mental Health Act. Only three groups of people are detained by the State against their will, those in prisons, immigration detention facilities and psychiatric hospitals. Independent oversight is an expectation of the United Nation Optional Protocol on the Convention on Torture.

- Then of course we can simply make the **economic case for change**.

- According to a recent report**,** Government spending per person on mental health has increased over time from $249 per person in 2005-06 to $317 per person in 2012-13. That's an increase of over 25%.

- Yet, mental illnesses are the third leading cause of disability burden in Australia, accounting for an estimated 27% of the total years lost due to disability.

- It is estimated that untreated mental health conditions cost Australian workplaces approximately $10.9 billion per year. This comprises $4.7 billion in absenteeism, $6.1 billion in presenteeism and $146 million in compensation claims.

Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019

- I now want to talk about the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019*, as a framework for how we can work together for system change.

- The Strategic Plan is not meant to be another well-intended, but ultimately meaningless dust catcher. It is not meant to be one of those great UNIMPLEMENTED policies.

- It is meant to be a blueprint for real, actionable change. That doesn't happen on a page. That happens through people like **<u>you</u>**.

- What the Strategic Plan does is set the vision and the direction for all of us.

- The Vision is for :

> *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*

- This might sound like a statement that was developed by a committee – and it was - but let me give some examples to illustrate why it has so many elements:

    - An *inclusive community* is one that reaches out, that proactively includes those sitting on the edge, that makes the phone call when they haven't seen someone for a while. That simply takes time to say hello in the supermarket.

    - Having a *life with purpose*, means having an opportunity to contribute and feel valued, through work, through volunteering, through education.

    - *access to quality care and support* – when it is needed, be it in primary care settings, in community organisations or in our public hospitals, care for both physical and mental health problems. Quality care means that services are designed based on what works. We have a sound evidence base for better services and we can put this knowledge into practice. This would ensure that precious public funds are used in a way that they will do the most good.

- This Strategic Plan has eight **Shared Commitments to Action.** The focus is on what we will aim to achieve and Action Plans will be developed progressively over the next couple of years**.**

- This Strategic Plan does not come with a commitment of new funds attached – but it does come with some high expectations that Action Plans will be developed and some of them will require a fresh look at funding.

- Let me give some examples.

- **Action 2** is about improving awareness, prevention and early intervention. The Commission will lead the development of a set of actions for what Queensland MIGHT do, and what the priorities are, and then we will have to negotiate with fund holders about what Queensland WILL do. The Commission has already demonstrated that more services are required for peri-natal mental health if we are to intervene early in children's lives. We have already argued that investment up front means lower costs AND better lives in the longer term.

- I am delighted that the State government has made a commitment to re-invest in health promotion and early intervention across the board.

- Once the Commonwealth Government releases its report on roles and responsibilities in the funding of mental health services we will be clearer about WHO will do what.

- Public discussion about what we MIGHT do starts in the week of 13 April with a series of forums hosted by Gregor Henderson who is an international leader in mental health and wellbeing. There will be at least one public event so watch the web site.

- **Action 3.3** – a Suicide Prevention Action Plan. In some ways this is easier for the Commission because we already have some funds invested so we are not starting at ground zero having to persuade everyone else to DO something.

- We are just completing a series of 'strategic conversations' to shape how we move forward. We will know we are making a difference when fewer people suicide, when fewer people attempt suicide and when more people are able to help people at risk of suicide.

- **Action 7** is a commitment to a new Mental Health, Alcohol and Drug Services Plan. Queensland Health is responsible for developing it. A plan that meets the needs of Queenslanders, that provides for a fair distribution of resources with services as close to home as is safe, is not cost neutral. It is about getting the balance right, and getting a fair balance, and arguing for additional resources, fairly distributed.

Be heard

- An action plan, no matter how well written, is of no use if it does not address the needs of people with mental illness or substance use issues. So, my one take home message for you today is: Be heard.

- To get the right responses and the right reforms the Commission needs to hear the experiences of consumers, families and carers. We need to hear the perspective of

grassroots service providers and clinicians. We need to work with academics and policy makers to establish best practice. We need to do the most important things, not the easiest things.

- Please make sure your voice is heard. Go to our web homepage www.qmhc.qld.gov.au and subscribe to our email news list. We will let you know about consultations, so you can participate.

- We will be experimenting with more responsive social media, maybe Facebook. I'm told Facebook focused on specific topics might make it easier for consumers and for staff to have their say. But be it by pen, phone, email, please keep in touch.

- Together we have a shared commitment to get it right.

- Thank you.