Queensland Mental Health Commission

Can we define the system we are reforming?

4th Annual National Mental Health Conference

29 November 2016

Australia talks a lot about system reform

Australia talks a lot about system reform. (Slide 1)

My perspectives on this are grounded in discussions about the role of my agency, the Queensland Mental Health Commission. The Commission's role in this is to drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health, drug and alcohol system in Queensland. (Slide 2)

In leading any reform, every leader must know themselves, know their environment, and know their business.

I don't need to tell this audience that system reform in mental health has an endless list of issues that need to be addressed.

So we have to keep our focus on what's important. (Slide 3)

This painting by well-known Australian artist Anne Wallace is very grounding. It is intentionally dark. It focuses on what can happen to people when things go wrong, when multiple government agencies are involved, and when you have system that is not accountable and does not follow through.

This is how Anne describes the painting –

> My painting depicts a small group of women in a boat on the Brisbane River. They were each, in their youth, wards of the State of Queensland who were placed in the psychiatric hospital sometimes called "Wolston Park". Many of them had experienced violence and neglect at home and were taken into care. Others were orphans, some had been "white babies" stolen from their indigenous parents. Most had exhibited bolshie behaviour whilst in care, were deemed uncontrollable and thus to be locked away. They were innocent children who found themselves in the "too hard basket", forced to live alongside adults in the forensic wards. They were subjected to ECT, strong psychotropic drugs and physical abuse. They also witnessed the horrific treatment of other vulnerable children and adults and the general culture of an institution described by a former on-site psychiatrist as a "whole universe of wrongness".

For years they have been caught between the child welfare arm of government that was responsible for their care, and the health department that placed them in adult mental health facilities and therefore outside the redress schemes for harm suffered in children's institutions.

The Queensland government issued an apology to them in 2010, 30-40 years after their incarceration and now in 2016, Queensland Health is committed to working with the survivors to consider redress.

What is the system

Define system

Most of us have an appreciation that it covers: (Slide 4)

- Mental health and wellbeing
- Mental illness
- Health issues associated with use of alcohol and other drugs
- Suicide prevention

One of the questions I reflect on often is what is the system? Is there one system or many?

And indeed some of the people we work with see themselves within only one of these four groups, although many of course identify as belonging to more than one, and others argue that the groups are so overlapping that they could be considered as one group.

I went to the Oxford English Dictionary rather than google.com and these are some of the various descriptors of a system:

- A complex whole
- A set of connected things or parts
- An organised body, arrangement or set up
- Orderliness
- Things functioning together

Certainly the mental health system is complex. But a complex whole? Connected parts? Organised? Orderliness? Functioning together? (Slide 5)

Consumer perspective

For those of us working within the system we may be able to see how different programs and services fit together and we might even see continuity of care being offered from high intensity acute care to community support and care through the Primary Health Network, and into schools and the workplace.

We ***may understand*** how a person needing help will be able to access these services and the entry points.

We ***may understand*** why the system involves so many parts, run by many different organisations and accessible in different ways.

We ***may understand*** the Commonwealth/State funding arrangements.

But what we really need to understand is that this is an insider's view.

For members of the public who need mental health treatment and care, the view is very different.

They often see a set of different systems that operate independently, use different approaches to access.

Parts of the system have their own cultures and ways of working.

For some, the system can appear to be a set of doors with very little direction about what the right door is.

Accessing the right service at the right time can seem like a matter of chance.

And if you have multiple needs, including those outside of the health system, for example housing and employment, you may well need to not only get to the right door in a complex health system but also in other systems.

For good reason, many feel frustrated and give up.

For although they simply want better mental health to enable them to live ordinary lives with purpose, individuals and their families are often left to navigate multiple systems.

In 2014, 39 per cent of people experiencing a mental health condition reported having difficulty accessing a range of services compared to 22.2 per cent of those not living with a mental health condition (nationally).

This doesn't seem good enough.

Machinery of government arrangements

I report to the Minister for Health, so often I see my agency portrayed as an element of mental health within a larger health system. In Queensland, we assume that alcohol and other drugs fits snugly within mental health.

At the national level, it is fair to say that most health portfolios, most health ministers and their major departments have similar mandates. Mental health broadly fits into that arrangement with its national governance groups. Alcohol and drugs as well as suicide prevention fit largely into that area. Even when separate agencies come and go in different jurisdictions *(are there any stand-alone alcohol and other drug agencies now that Western Australia has finally merged their AOD Office with the MHC?)* they tend to stay within the health portfolio unless they are suddenly whisked off to the First Minister or to a mental health portfolio. Still the links I suggest are largely intact.

I've sought a number of times to understand where leadership for reducing the burden associated with foetal alcohol syndrome disorder fits? Its cause is alcohol, its result is physical and mental impairment with many children ending up in foster care and then in the justice system.

And mental health and wellbeing?

I look to the agencies outside the health portfolio that we are working with in a collective effort to improve mental health and wellbeing across Queensland. There are in fact 26 agencies contributing to whole-of-government action plans.

We all expect this to include health, schools, communities, police and so on. But it also includes agencies like Railways and Natural Mines and Resources.

Then when I look at the private and non-government organisations, and the local governments, that are concerned about mental health and wellbeing we move even further from the traditional health system. We also have major organisations operating at State, national and international levels and small local businesses in this business.

These organisations, inside and outside health, take such different perspectives, from concern for employees and their families to impact on the bottom line. Success will be seen in many forms.

Who do these systems serve?

Consumers?

The answer to this question seems obvious. People with mental health issues, of course.

But asking the question is important. It makes us think beyond the service we are providing to the systems and processes involved in accessing a service.

One very important and contemporary example is the NDIS. From a high level policy point of view, the service being provided by the NDIS is insurance.

However from a consumer perspective the service is a personalised package of supports.

We heard yesterday about the experience of consumers, families and carers in accessing NDIS supports. What strikes me about the NDIS is that consumers and others need to take a set of steps which can be complex in order to enable the NDIS to determine whether they are eligible for supports.

In Queensland there have been a number of organisations funded to support consumers to be ready for the NDIS.

From a consumer point of view, it can appear that the system is requiring them to be ready rather than the system being ready for them.

I am not suggesting that consumers should not have to take steps to be eligible or that they are not supported in taking those steps.

Rather I am asking the question, do we get the balance right between our focus on system readiness rather than on consumer readiness. Consumers must be at the centre or we will have an efficient system but not the right outcomes.

Mark Bagshaw's recent comments on the composition of the Board say it well[1]:

> *The Able Movement believes that, just like any other large and complex enterprise, the Board of the NDIA needs a range of skills and experiences … It needs people who understand finance and investment and .. insurance. … but three things are absolutely critical. First, every member of the Board must be driven by an **aspirational view** of the capacity of people with disability. … Second, the Board must have **a deep understanding,** not just of the "disability support system", but of the entire life experience of people with disability. …. And third, the Board needs to be **trusted** by people with disability to understand their aspirations and needs, and to fight for their right to control their own lives.*

Or bureaucrats?

Quite apart from dedicated roles within many public sector agencies, mental health has a complex set of structures within each state and across the nation within health portfolios. There are many roles for many bureaucrats and the system does need to be organised so that they can do their jobs effectively. They include roles like:

- Chief Psychiatrists
- Mental health branches

[1] http://www.theablemovement.com.au/a-new-ndia-board-a-litmus-test-for-the-ndis/

- Community or official visitors
- Review tribunals
- Health Ombudsmen and the like (Queensland) or Mental Health Complaints Commissions (Victoria)
- Alcohol and other drugs units sometimes combined with mental health, other times separate as they now are in New South Wales and Victoria
- Public health units, sometimes address stigma and discrimination about mental health, sometimes not
- Mental health commissions
- And within the non-government sector, mental health peaks that focus on consumers, families and services as well as others with specific focus on suicide prevention or alcohol and other drugs.

In justice are various courts and tribunals, including the Mental Health Court in Queensland and the Mentally Impaired Accused Review Board in Western Australia for example.

Then of course there is a Principal Committee reporting to Ministers, and advisory committees with more recommended in the 5th National Mental Health Plan where we need to get the nexus between mental health and alcohol and other drugs right.

In all these structures there are different levels of access to power, and there are careers. I leave it to the audience to make your own assessments about the extent to which policies, services or appointments are informed by lived experience perspectives.

Are our reforms making a difference?

Australia has done reasonably well in defining the longer term outcomes (or impacts) our reforms in 'mental health' hope to achieve. These are repeated in the draft 5th National Mental Health Plan. (Slide 6)

- More people will have good mental health and wellbeing.
- More people living with mental health issues will recover and have a meaningful and contributing life.
- More people living with mental health issues will have good physical health and live longer.
- More people will have a positive experience of care and support from a responsive and effective service system.
- Fewer people will suffer avoidable harm.
- Fewer people will experience stigma and discrimination.

But these outcomes are influenced by many things and it will take some time to demonstrate progress.

To keep change on track, we need systems and processes: what I call the 3Rs — Rhythm, Routine and Relentless — I follow up.

I read a recent article suggesting that health systems are often characterised by 'profound forces which resist change' – suggesting that there is a health system and that reform may be a challenge[2].

I liken these profound forces to elephants. (Slide 7)

There are two ways of working with elephants that are in your way – rather than eating them a piece at a time, I would rather persuade them to do the heavy lifting. Without persuading Health to do the heavy lifting for the Wolston Park group I referred to at the outset, there would still be nothing happening. (Slide 8)

We read often about the additional investment in mental health at both State and Commonwealth levels. And we also hear a lot about the need to ring fence the mental health dollar.

It's interesting that non-government organisations are required to return funds not spent on the program for which they were provided and yet in the public sector we are not even sure what was spent.

The Western Australian Mental Health Commission was established with a primary goal to address this issue. They have decided to take a biggish bite out of the health elephant.

In Queensland, we have decided to try to persuade the elephant to do the heavy lifting. We have a joint project currently underway that maps the funds allocated to mental health through the State and what we know about how it is spent. Suffice to say, we are still looking. But if we are to persuade the Health Department that it is important to show how that money is acquitted, we need to work with them to develop solutions. I anticipate a paper on our findings in the first half of 2017.

If governments are going to invest in reform, this must be accompanied by processes to ensure that investment is spent as intended. This goes to the heart of devolution to Local Health Services. It must come with robust systems of transparency and accountability.

Understanding whether or not we are making a difference and what particular actions can be attributed to that difference in a collective enterprise is one of the challenges when there are many players contributing to a common outcome.

For those like my agency, who 'get their achievements through the achievements of others' this is particularly hard. Without frontline staff, health bureaucracies would be powerless.

The recent publication by the Centre for Public Impact highlights the importance of three things fundamental to making a difference: Legitimacy, Policy and Action[3].

- Legitimacy requires public confidence, stakeholder engagement and political commitment
- Policy requires clear objectives, evidence and feasibility
- Action requires management, measurement and alignment.

Being a bit of a measurement junkie, or rather someone who believes that if it's important enough to do, it's important enough to measure, my organisation has done an annual stakeholder survey each year since its inception in 2013. One of the things we measure is our credibility – if we are not

[2] Braithwaite J, Matsuyama Y, Mannon R, Johnson J, Bates D, Hughes C. How to do better health reform: a snapshot of change and improvement initiatives in the health systems of 30 countries. International Journal of Quality in Health Care. 2016:1-4.

[3] Centre for Public Impact. The Public Impact Fundamentals: Helping governments progress from idea to impact. 2016.

credible we lack legitimacy and no matter how hard we work, we will not be able to influence and get those elephants doing the heavy lifting.

We also ask about perceptions of improving lives.

How do we make best use of our collective effort?

Know your times - *The facts of the times* (Slide 9)

In Australia we have many many statistics, we need to use them to inform our planning.

- One in five will have a mental health problem some time during the year. One in three of them report discrimination or unfair treatment
- One in five aged 14 and over report drinking at life time risky levels (Queensland is above the average)[4]
- 15 per cent regularly used an illicit drug in last 12 months[5]
- 4 per cent misused pharmaceutical drugs in last 12 months[6]
- Suicide rates in Queensland are 13.7 per 100,000 compared with 12.0 nationally (2014)
- Suicide rates for Indigenous people are almost twice the rest of the population (20.5)
- As many as 23 per cent of young people with Fetal Alcohol Spectrum Disorder may be incarcerated and 60 per cent are in touch with the justice system[7]
- The average first age use of tobacco in Queensland in 15.9 compared with 16.2 nationally.[8]

The draft 5th National Mental Health Plan proposes a range of population level performance indicators. We have started this process in Queensland with an annual report. Our measures must be: (Slide 10)

- Meaningful and shared
- Appropriate and useful
- Feasible and cost effective
- Robust (all the features of a measure that would make a statistician happy)

Know your times - *The nature of the times* (Slide 11)

To describe that environment I like to draw on an acronym in the leadership literature, taken I understand like so much of our leadership ideas from the military: VUCA

- V = Volatility
- U = Uncertainty
- C = Complexity

---

[4] This data pertains to people aged 14 years and older who reported use in the past 12 months, 2013. The National rate is 18.2 per cent and the Queensland rate 20.2 per cent. Source: Australian Institute of Health and Welfare (2014), National Drug Strategy Household Survey detailed report 2013, Australian Institute of Health and Welfare, Canberra.

[5] This data pertains to people aged 14 years and older who reported use in the past 12 months, 2013. The National rate is 15 per cent and the Queensland rate is 15.5 per cent. Source: Australian Institute of Health and Welfare (2014), National Drug Strategy Household Survey detailed report 2013, Australian Institute of Health and Welfare, Canberra.

[6] Op. cit., Australian Institute of Health and Welfare (2014)

[7] http://sydney.edu.au/news-opinion/news/2015/10/14/young-offenders-must-be-screened-for-fetal-alcohol-spectrum-diso.html

[8] Op. cit., Australian Institute of Health and Welfare (2014)

- A = Ambiguity

The definitions that I like come from something I found on the web[9] – where else?

1. Volatility – *the rate, amount, and magnitude of change*

Drastic, rapid shifts can bring about instability for organisations and leaders - one news article can shift priorities within minutes.

2. Uncertainty – *the amount of unpredictability inherent in issues and events*

We lack clarity about the challenges and our current and future outcomes. Uncertainty can result in an over-reliance on past experiences or to analysis paralysis.

3. Complexity – *the amount of dependency and interactive effect of multiple factors and drivers*

Complex interactivity requires us to think in more creative and innovative ways; to be able to deal with shades of gray. In satisfying the needs of one group, the needs of another are often compromised. In satisfying families who want their loved ones kept safe, sometimes they are detained against their will.

4. Ambiguity – *the degree to which information, situations, and events can be interpreted in multiple ways*

Ambiguity increases doubt, slows decision-making, and results in missed opportunities. It requires us to think through *multiple* perspectives.

And to succeed in these VUCA times, we need a VUCA response: (Slide 12)

- To cope with Volatility — we need Vision
- In times of Uncertainty — we need Understanding
- To address Complexity — we must seek Clarity[10]
- When there is Ambiguity — we must have Agility

If I could summarise a whole book in a few lines, the importance of a common vision for collaborative outcomes in complex times cannot be overrated[11].

Without a common vision: (Slide 13)

- There will be unintended consequences
- Delivery targets will not be met in inter-related systems – others think implementers are letting things drift
- There will be interference from others
- Interventions will be required to cope with the events
- And if adjustments are not made there will be acrimony and blame between senior managers and implementers.

---

[9] by Andrew Cooke, Growth & Profit Solutions, https://growthandprofit.me/2013/04/30/how-to-manage-volatility-uncertainty-complexity-and-ambiguity/

[10] (even to be clear that things are unclear is progress)

[11] Chapman J. System Failure: Why Governments Must Learn to Think Differently. London: Demos; 2004.

– it is a predictable outcome when there has not been sufficient attention to accommodating different perspectives from the beginning in complex policy areas.

I think everyone here would agree with me that the mental health, alcohol and drug, suicide prevention environment is (or should I say environments are) an excellent example of the VUCA times.

Leadership

Change won't happen without leadership.

When it comes to the role of leadership in times of change and uncertainty, and how each of us goes about it, we need to understand ourselves, the environment and the business we are in. (Slide 14)

We hear a lot now about agile leadership. I see that as more than a way of thinking. Our rhythms and routines must also be agile. To me, Queensland's approach to our mental health strategic plan is agile. We have developed a high level plan with related Action Plans at regular intervals. This allows us to adjust quickly to emerging issues and opportunities while being focused on our long term vision. (Slide 15)

Knowing your strengths and weaknesses, and your passions, will help prioritise, it will see you live to try, try again. Maybe some people are better at eating elephants than cajoling them.

VUCA theory tells us we need deeper wisdom, resilience, compassion and skilfulness. I would like to add authenticity to that list. (Slide 16)

To me, authenticity is about:

- Creating change through vision you really believe in and inspiration not by power and control – persuade the elephant to work with you, don't try to eat it (or make it dance).
- The ability to influence followers by establishing positive partnerships, empowering individuals, to work towards a common vision.
- Enabling others to lead.

The role of leadership to me in time of change and uncertainty is very much about enabling others to lead, preparing for the time when you can walk away confident that positive changes will continue to evolve.

Without the right leadership, reform will remain a light on the horizon.

Without the right leadership, we will write policy and plans and still the lives of the most vulnerable will not improve. (Slide 17)

To make best use of our collective effort, we need a common vision that keeps us focused on the most vulnerable in our society. We need the leadership and the rhythms and routines to deal with complexity.

Thank you (Slide 18)

ENDS